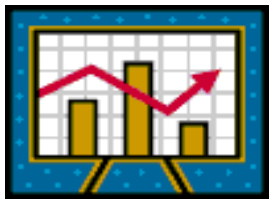
Capital Health

CAPITAL HEALTH'S STRATEGIC INDICATORS REPORT

June 2012



Prepared for the Board of Directors and the Quality and Patient Safety Committee of the Board

Prepared by Decision Support
June 21, 2012

1 Table of Contents and Indicator Summary

The indicators in this report are summarized in the table below. A short description of the current status is also provided. Note the icons below used in the summary. A summary that is specific to the progress towards the 2010/11 targets of the 2013 Milestones (updated May 2011) can be found in Appendix A.


Meeting target or on track to meet target


Not meeting or will not meet target


Caution – needs work to meet target


Trending toward target


New to the current version of the report

B Baseline measurement only at the present time

◆ Being tracked but with no established target or standard.

*** Click on an indicator name to go directly to that section ***

Target	Indicator Name	Status / Comment	Page
☑☑☒	Wait Times - Open Heart Surgery	Meeting target for urgent and scheduled cases. Not meeting target for semi-urgent cases.	26
☒☑	Wait Times - Average Time from Triage to Physician in the Emergency Department	CTAS level V wait times meeting target for all facilities, except the DGH; CTAS levels II-IV not meeting targets for any facilities.	28
△	Patient Appointment No Show & Cancellation Rates	Examples of work already done in this area in Mental Health and the Department of Medicine are provided.	33
☒	Length of Stay - Percentage of Case Mix Groups Meeting Expected Length of Stay Target	For 2011/12, 50% of CMGs had an ALOS less than or equal to the ELOS. This is short of the target of 70%.	37
☒	Length of Stay - Number of Conservable Days	The 2011/12 target was not met. There was a 19% increase instead of the 4% decrease target.	39
☒	Length of Stay - Average Length of Stay and Expected Length of Stay Comparison	For 2011/12, the difference between LOS and ELOS was 0.3 days. This is the same as it was in 2008/09 and 2009/10.	41
☒	Occupancy Rates	The total occupancy rates for QEII & DGH were above the 2011/12 target of 91%.	43
☑☑	Incidence and Transmission Rates - MRSA	Better than the 2009 national rates for both incidence and transmission.	46
☑	Incidence Rate - VRE	Better than the 2009 national rate.	49
☑	Infection Rate - C. difficile	Better than the 2009 national rate.	51
☑	Hand Hygiene Compliance	The 2011 calendar-year audit shows CDHA is better than the 2008 Ontario hand hygiene compliance rate and better than the 2010 CDHA audit rate.	53
☒	Emergency Department - Percentage of Patients Left Without Being Seen	No sites are meeting the target of 2% or less.	55
☒	Long Term Care - Patients Placed and Waiting to be Placed	Above target of 75 patients waiting to be placed.	57
☑	Code Blue Count (Impact of Quick Response Team)	In 2011/12, the target of 3 or fewer code blues per month has been met, with the exception of January and February.	60
☑	Hospital Standardized Mortality Ratio	CDHA's HSMR for Q1-Q3 of 2011/12 is on par with the 2009/10 national average.	62
☑	Patient Satisfaction	In 2010/11 and for both inpatient and ambulatory care patients, the percent of positive responses remains at or above the target of 90%.	64
◆	Patient Safety Culture	No target set. 2010 survey shows improvement over 2006.	66

Target	Indicator Name	Status / Comment	Page
☒	Completion of Patient Safety Training	In 2011/12, 25% completed at least one patient safety training course. The target is 100%.	68
Sustainability			
☑	Access to a Primary Health Care Team	As of March 2011, there were approximately 20% of family physicians (in full service practices) that practice within an interdisciplinary team.	70
☑	Increased Investment in Primary Care & Care of the Elderly	Targeted investment money in the amount of $690,000 has been authorized for the 2011/12 fiscal year, thus the 2011/12 target has been met.	71
☒	Percent of Alternate Level of Care Beds Vacated and Closed Permanently	As of June 11, 2012, there was a decrease of 38% of beds from the 2009/10 baseline. This is short of the 2012/13 target of 75% of beds closed.	72
△	Improved Metabolic Targets for Pre-Diabetes and Diabetes	In 2010/11, there was an increase of 18.8% in the number of patients within the acceptable HbA1C target—exceeding the 2010/11 target of 10%. Awaiting more recent data from Diabetes Care NS.	73
☒	Admissions for Identified Chronic Diseases	In 2011/12, for all three diseases combined, there was an increase of 5% over the baseline year. This is short of the 2011/12 target of a 2% decrease. Individually, none of the diseases met the target.	74
☒	Readmission Rates for Cohorts with Complex Chronic Disease	In 2011/12, the readmission rate for diabetes met the 2011/12 target, but the rates for COPD and heart failure/pulmonary edema did not. All three diseases combined showed a 16% increase over the baseline. This is over the 2011/12 target of a 5% decrease.	78
☑	Nursing Home Patients Seen in the Emergency Department	The 2011/12 target of a 15% decrease from the baseline was surpassed with an actual decrease of 32%. Also on track to meet the 2012/13 target.	82
◆	Length of Stay - Average Length of Stay for Patients Discharged to Long Term Care	No target. Fluctuations seen from month to month, especially at the NSH.	84
Transformational Leadership			
☒	Absenteeism	In the first month of 2012/13, average sick hours were 7.6% lower than the baseline. This is an improvement but short of the 10% decrease target for 2012/13.	86
☑	Overtime – Percent of Overtime Hours Worked	In 2011/12, there was a 37% decrease from the baseline—surpassing the 2011/12 target of a 7% decrease. On track for 2012/13 as well.	88
☑	Recruitment for Hard-to-Fill Positions	Has met the 2011/12 target.	90
☑	Alignment of Medical Departments and Operational Structures	On track to meet the 2012/13 target.	91

Target	Indicator Name	Status / Comment	Page
☒	Compliance with Performance Evaluation Process	For 2011/12, 38% of employees had performance evaluations completed. The 75% target for this fiscal year was not met.	92
△	Formal Leaders Demonstrate Transformational Leadership Capabilities	2011 Employee Survey results show leader performance has risen on the dimensions of Being and Doing. Results on the Caring dimension fell slightly. New measures of this indicator are planned for Sept. 2012.	94
◆	Employee Survey	Pride, trust in peers, and spiritual wellness are areas to celebrate. Some of the areas for improvement include psychological safety, involvement in decision making, & trust in management.	96
◆	Physician Survey	Of the 6 sections presented in this report, trust in colleagues and respect had the highest percentage of favourable responses, while trust in Capital Health management and engagement with Capital Health had the lowest.	98
Citizen Engagement and Accountability			
☒	Receipt of Health Passport	Efforts will now focus on communication and engagement of groups that are best positioned to promote the passport.	100
☑	Influence Change in Three Major Public Policies	Met the 2011/12 target.	101
△	Access for Underserved / Vulnerable Groups	Indicator is under development. Work is underway to improve access for several underserved/vulnerable groups.	103
☒	Patient Involvement in Patient Care Committees	55% of quality teams, councils, and committees in CDHA have patient or family representatives (41 of 75). This is short of the 2011/12 target of 90%.	104
☒	Immunization Rate - Capital Health Flu Campaign	Not meeting target of 70%. 2011/12 is higher than the 2010/11 rate.	105
Innovation and Learning			
☑	Models of Care Implementation in Patient Care Service Areas	Has been implemented in 90% of in-patient units. As well, five of eight additional health care disciplines have completed work to differentiate practice within their disciplines.	107
△	Service Duplication & Fragmentation in Ambulatory Services	Target year plan is to identify opportunities to streamline non-value added or duplicate efforts, such as the installation of self-registration kiosk clusters in key areas.	108
☒	Ambulatory Care Visits	The VPs of Person-Centred Health are poised to activate with their directors and managers, the actual plan to attain targets.	109

2 INTRODUCTION

Capital Health's Strategic Indicator Report is a stimulus for quality improvement as it provides multi-year data on key indicators identified by Capital Health stakeholders. Over the summer and fall of 2009, leaders within Capital Health were asked to identify strategic indicators which would aid in their work to fulfill "Our Promise" to become a world-leading haven for people-centred health, healing, and learning. This process resulted in the creation of the Capital Health Indicator Development document which itemizes indicators by five Strategic Streams:

1. **Person-Centred Health Care**
2. **Sustainability**
3. **Transformational Leadership**
4. **Citizen Engagement & Accountability**
5. **Innovation & Learning**

Appendix B provides a detailed description of the strategic streams (as well as the eight Qmentum Quality Dimensions outlined by Accreditation Canada). Capital Health's Strategic Indicators Report is organized around these five streams as is the Capital Health Milestones for 2013, and the Quality and Patient Safety Framework (Appendix C). For additional information on Capital Health's "Our Promise", please visit the Capital Health website at www.ourpromise.ca.

Each of the indicators in this report is described in detail in its own description table which includes:

- Indicator name
- The associated Strategic Stream
- Status – whether or not the goal is being met
- Trend – a short description of the recent or long term pattern of the indicator, if applicable
- Formula – an explanation of how the indicator is calculated
- Description – background information presented to help understand the indicator and the targets
- Analysis and Progress – a summary of the trend of the indicator and how it compares to the target
- Source – the origin of the data used to calculate the indicator and the source for the analysis and progress update
- Frequency tracked – how often the indicator is reported
- Last Updated – the date of the last update to the indicator and /or analysis and progress
- Accountability – the names of VPs, directors, and other people who share responsibility for reaching the targets
- Next Update Expected – estimated time frame for the next update

Throughout the report, the following icons appear above selected indicator description tables:

The **star icon** identifies indicators that are **new** to the current version of this report

The **2013 Milestone** icon identifies indicators that are part of the **Our Promise: 2013 Milestones**

The **Our Promise** icon specifies an **evidence of transformation** indicator.

The **Patients First** icon specifies a **patient safety** indicator.

Indicator selection is based on the Capital Health Milestones for 2013 and the Capital Health Indicator Development document. Many of the indicators in these two documents are still in the development stage as indicator definitions, inclusion and exclusion criteria, and data sources are still being identified. As these elements are completed for each of the indicators, they will be added to the Capital Health's Strategic Indicators Report.

This report provides a consistent set of key strategic indicators and an analysis of the results. All indicators will be reported in each publication, although some indicators will be updated less frequently. For example, data from Capital Health's Flu Campaign is available annually; however, the indicator will remain in each publication. This will ensure regular, consistent access to key strategic indicators. Where possible, indicators are reported at the district level to provide an overall picture of district-wide activities. The Capital Health Strategic Indicators Report will be posted on the Capital District Health Authority's website to ensure easy and broad access.

Data Quality and Revisions

The numbers presented in the graphs, tables, and narratives of this report come from a variety of sources. Every effort is made to ensure the data are accurate at the time of publication. Each publication only provides updated data for the most recently available time periods. Data from past time periods are not revised each time the report is published, so changes or corrections made to historical source data are not reflected in this report. Historical changes are carried over to the report when indicator definitions or data collection methods are changed. It should be noted that when such changes are made, they are not made to older versions of this report.

External Links

This report may provide links to other Internet sites only for the convenience of readers. Capital Health is not responsible for the availability or content of these external sites and cannot guarantee that the information is current or accurate. This information is provided as a public service. Readers should verify the information before acting on it. Capital Health does not endorse, warrant or guarantee the products, services or information described or offered at any other Internet sites. Capital Health does not assume and is not responsible for any liability whatsoever arising from the linking to any linked website, the operation or content (including the right to display such information) of any linked website, or for any of the information, interpretation, comments, or opinions expressed in any linked website. Any comments or inquiries regarding the linked websites are to be directed to the organization operating the website.

Contributors

This report would not be possible without the contributions of data, background information, and insights provided by many people at Capital Health. A list of those who are to be acknowledged for their valued contributions are listed in Appendix D

3 Indicators

3.1 Person-Centered Health Care

This section contains indicators focused on measuring patient and family satisfaction, whether care makes sense to patients and families, if citizens access services they need, and whether citizens get safe, quality, and compassionate care.

3.1.1 Elimination of Shadow Charts

Strategic Stream: Person-Centered Health Care

Status: ☒ Did not meet the 2011/12 target	Trend: Improved 6% from last update (September 2011)

Formula: Number of service areas transitioned away from shadow charts divided by the number of service areas identified as having shadow charts.

Description: Shadow charts are health records maintained at the service level separate from the organizational central patient record. They pose a risk to patient care as they may contain pertinent health information not widely available to all practitioners. The maintenance of shadow charts also consumes valuable time, resources, and space that should be directed toward clinical services.

Capital Health's Our Promise Milestone target is to ensure all pertinent patient information is maintained in the organization's central health record by eliminating shadow charts by 25% by 2010/11, by 50% by 2011/12, and by 100% by fiscal year 2012/13.

Analysis and Progress: IBD Shadow chart elimination is complete. Medical Day Unit has completed 85% elimination and should be complete by the end of the fiscal year. There have been two additional service areas added to the list: Donor Charts for Bone Marrow Transplant and Sleep Lab. Preliminary discussions to begin work have been held with both of these areas as well as the Pacemaker Clinic. This brings the total service areas identified to 67. The previous milestone update (September 2011) showed 23% of total areas with work underway to meet the milestone target. Milestone tracking is now at 29% which is short of the target of 50% for 2001/12.

Meetings continue with service areas to assist them with chart management. While progress is not as far as hoped, attention and concern regarding the elimination of shadow charts has changed notably over the last 3 years. Senior clinical leaders now contact HIS and are working collaboratively and creatively to make progress. Some technology has been used to help create interim electronic forms to help bridge to the time when an EMR fully operational.

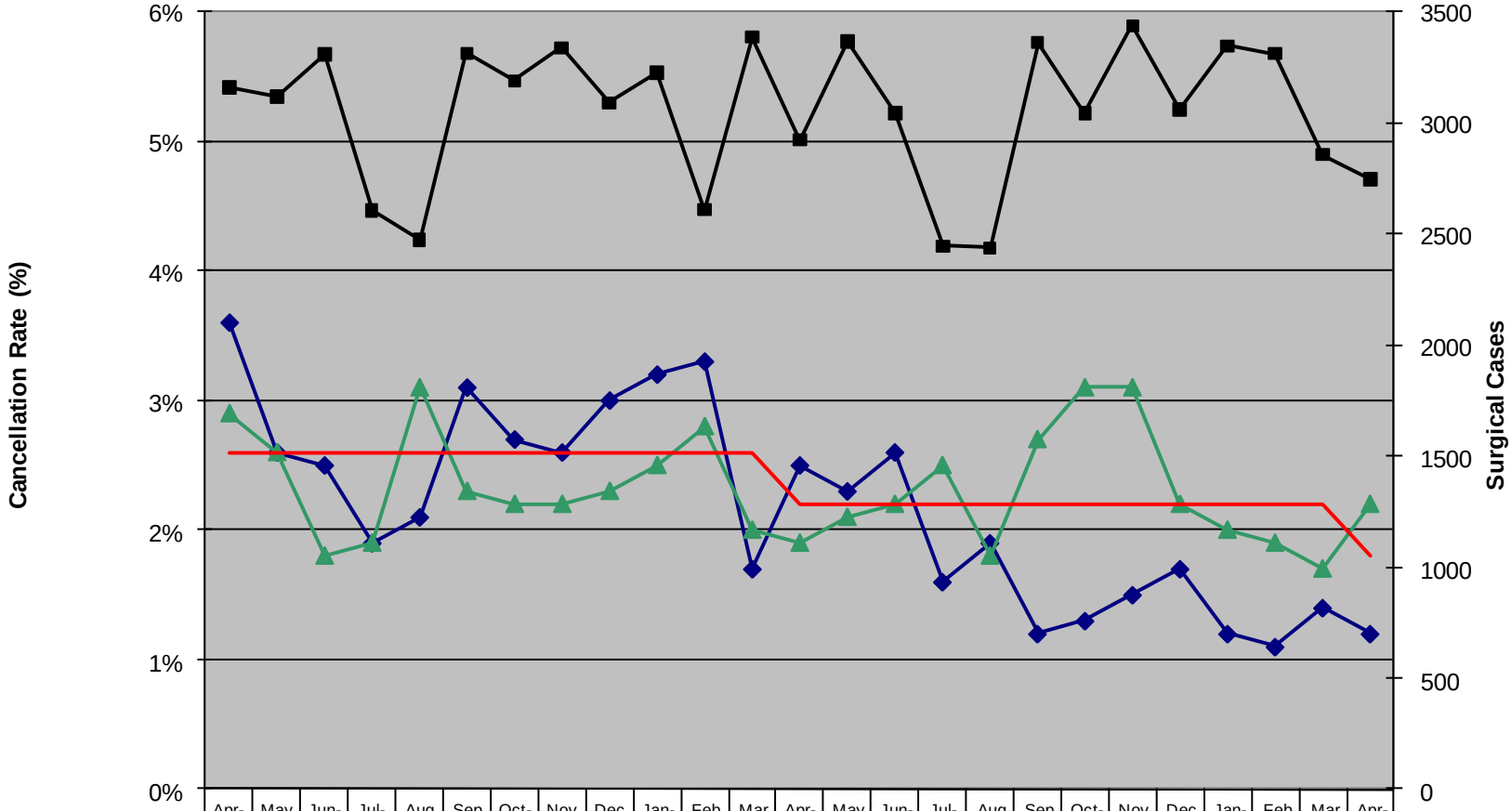
Source: eHealth/Medical Services	Frequency Tracked: Quarterly	Last Updated: May 2012
Accountability: Amanda Whitewood & Ray LeBlanc		Next Update Expected: August 2012

3.1.2 Surgery Cancellation Rates		
Strategic Stream: Person-Centered Health Care		
Status: ☑ Met the 2011/12 target	Trend: Resource- and patient-related cancellations are decreasing in the long term.	
Formula: The cancellation rate (%) is calculated by dividing the number of patient- or hospital-related cancellations by the total number of elective surgical cases and then multiplying by 100. All ORs and services at the QEII, Dartmouth, and Hants are included.		
Description: Cancelled surgeries are classified into two categories: 1) those cancelled for reasons originating in the hospital (resource related or preventable) and 2) those cancelled for reasons originating from the patient. Cancellations related to booking errors, change of dates, wrong patient scheduled, duplicate booking at other hospitals, booked in error, surgery already performed, received earlier booking, or for coordination with other appointments are excluded from the calculations. The *Our Promise: 2013 Milestone* is to decrease *preventable* (resource-related) cancellations by 25% by 2010/11 (target 2.6%), by 35% by 2011/12 (target 2.3%) and by 50% by 2012/13 (target 1.8%). January 2010 has been designated as the baseline (cancellation rate of 3.4%).		
Analysis and Progress: The graph below shows monthly cancellation rates for the most recent two-year period. The targets for resource-related cancellations for 2010/11 and 2011/12 were met. The first month of 2012/13 shows an increase in resource-related cancellations to a level above the 2012/13 target, but data from upcoming months will show if this continues or reverses. Following the graph is a table showing a breakdown by facility of the patient- and resource-related surgical cancellation rates and total surgeries for two recent months. Key reasons for resource-related cancellation in April include: 22 cases that were related to lack of elective time. All services were affected by this. This included effects of strike planning. Nine cases were cancelled related to trauma cases bumping booked cases. There were 11 cases cancelled due to lack of beds with the majority of these being at DGH. Strategies in place to reduce cancellations: An initiative has started that will review CV booking processes in an attempt to reduce patient cancellations. Also, methodology is being identified to track more detail regarding lack of elective time to try to ascertain key challenges for this category.		
Source: HBI, Karen Mumford	Frequency Tracked: Monthly	Last Updated: June 2012
Accountability: Paula Bond, Karen Mumford, All Surgical District Department Chiefs		Next Update Expected: July 2012

Capital District Surgical Cancellation Rate

Resource- & Patient-Related Reasons

April 2010 to April 2012



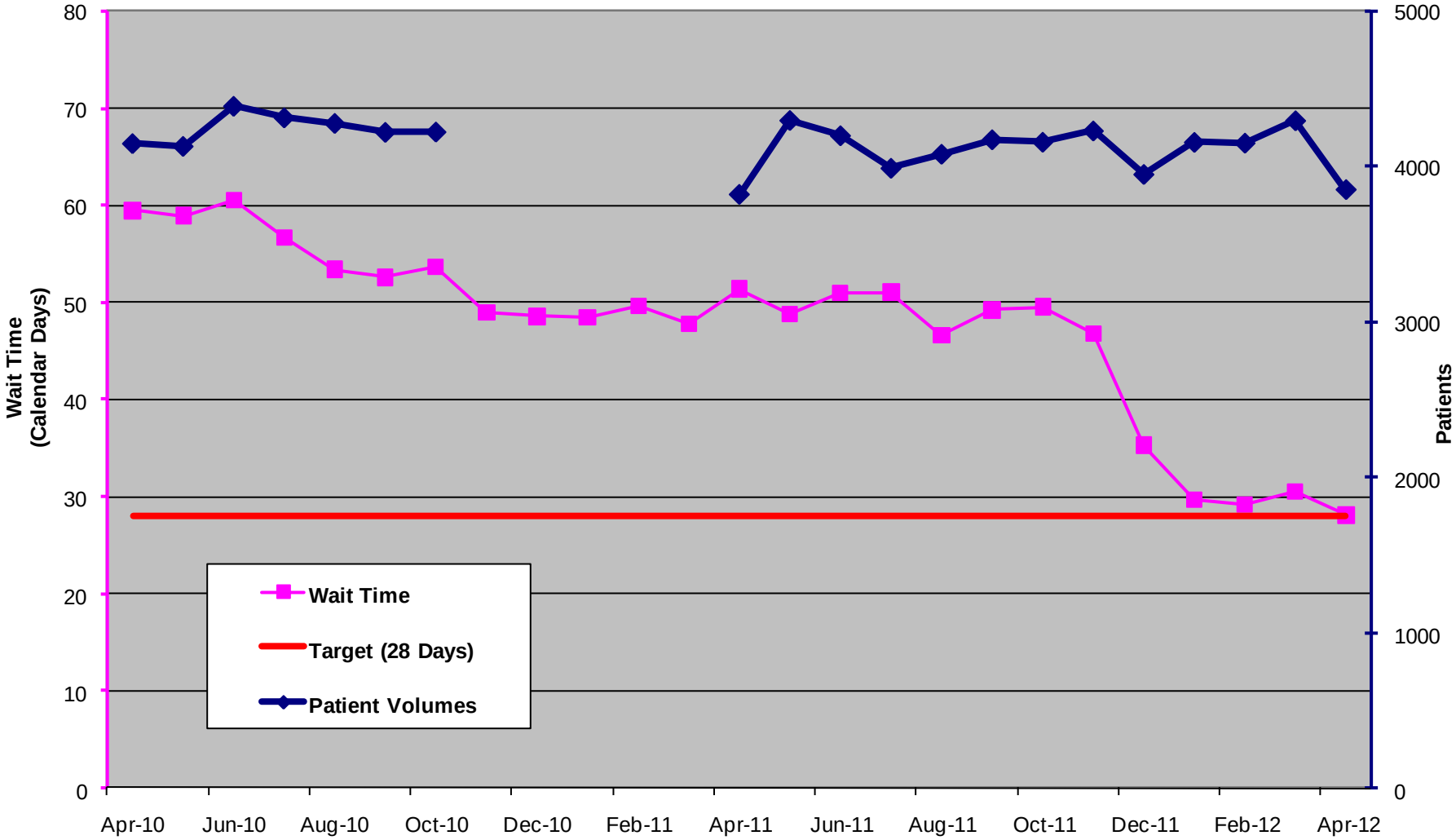
	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12
Patient-Related Cancellations	3.6%	2.6%	2.5%	1.9%	2.1%	3.1%	2.7%	2.6%	3.0%	3.2%	3.3%	1.7%	2.5%	2.3%	2.6%	1.6%	1.9%	1.2%	1.3%	1.5%	1.7%	1.2%	1.1%	1.4%	1.2%
Resource-Related Cancellations	2.9%	2.6%	1.8%	1.9%	3.1%	2.3%	2.2%	2.2%	2.3%	2.5%	2.8%	2.0%	1.9%	2.1%	2.2%	2.5%	1.8%	2.7%	3.1%	3.1%	2.2%	2.0%	1.9%	1.7%	2.2%
Milestone Target Rate	2.6%	2.6%	2.6%	2.6%	2.6%	2.6%	2.6%	2.6%	2.6%	2.6%	2.6%	2.6%	2.2%	2.2%	2.2%	2.2%	2.2%	2.2%	2.2%	2.2%	2.2%	2.2%	2.2%	2.2%	1.8%
Total Surgical Cases	3161	3121	3312	2608	2476	3314	3190	3340	3091	3227	2610	3388	2924	3365	3045	2446	2438	3363	3046	3438	3063	3347	3313	2858	2749

Patient- and Hospital-Related Surgical Cancellation Rates & Total Surgeries for Recent Months

Facility	March 2012			April 2012		
	Patient-Related Cancellations	Resource-Related Cancellation	Total Surgeries	Patient-Related Cancellations	Resource-Related Cancellations	Total Surgeries
HI	1.0%	2.4%	960	0.3%	2.1%	905
VG	1.1%	0.7%	1,234	0.8%	1.8%	1,236
DGH	3.3%	2.9%	523	4.0%	4.0%	495
HCH	0.7%	0.7%	141	0.0%	0.0%	113

3.1.3 Wait Times - Elective CT		
Strategic Stream: Person-Centered Health Care		
Status: ☑ Meeting target	Trend: Recent improvements	
Formula: Weighted average wait time for elective CT, at QEII, DGH, and Cobequid combined (weighted as 23% cranial, 7% spine, 19% chest, 25% musculoskeletal, and 25% abdominal).		
Description: Computed tomography (CT) is a special radiographic technique that uses a computer to assimilate multiple x-ray images into a two-dimensional cross-sectional image. This can reveal many soft tissue structures not shown by conventional radiography. Scans may also be dynamic in which movement of a dye within the body is tracked. The machine rotates 180 degrees around the body sending a thin x-ray beam at 160 different points. Using the same dosage of radiation as that of a conventional x-ray, an entire slice of the body is made visible with about 100 times more clarity. The five types of elective CT used to calculate the wait time are: cranial, spine, chest, musculoskeletal, and abdominal. Wait times have been converted to calendar days. The elective CT wait times are weighted based on volume of procedures as suggested by the Department of Health (see weights above under "Formula"). The target wait time for CT is 28 days.		
Analysis and Progress: The graphs below show the wait times and patient volumes for elective CT at Capital Health. This is the weighted average for the QEII, Dartmouth General, and the Cobequid Community Health Centre combined. It can be seen that there have been great improvements recently and the average wait time for April 2012 was 28 days—right on the target. Capital Health received funding from the Department of Health and Wellness to replace an end-of-life CT scanner at the Halifax Infirmary site of the QEII. The new scanner has been up and running since March 31, 2011. To see recent wait times for elective CT at locations in Nova Scotia click here.		
Source: Diagnostic Imaging	Frequency Tracked: Monthly	Last Updated: June 2012
Accountability: Paula Bond, David Barnes, Susan Delaney		Next Update Expected: July 2012

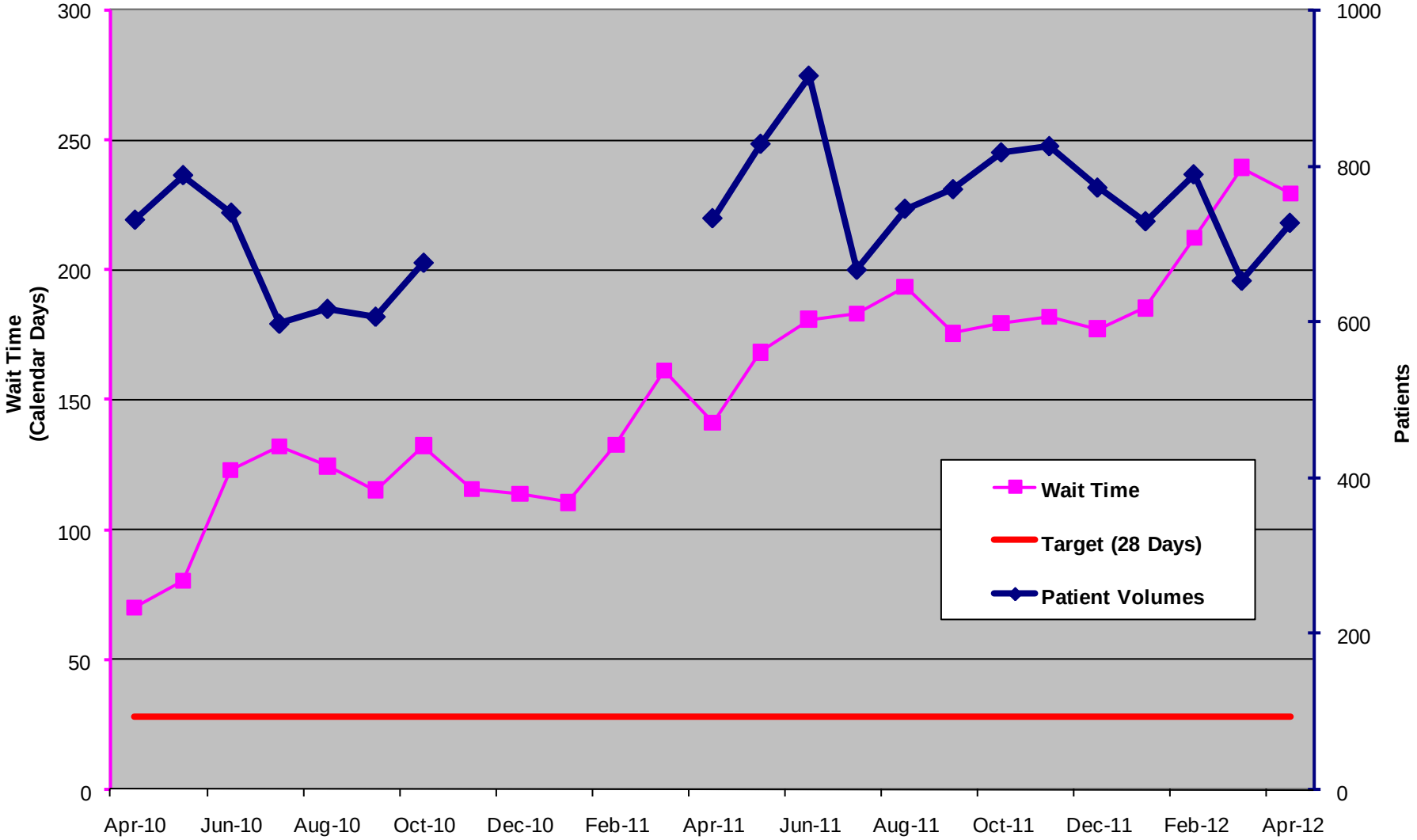
Wait Times & Patient Volumes for Elective CT at Capital Health - April 2010 to April 2012



3.1.4 Wait Times - Elective MRI		
Strategic Stream: Person-Centered Health Care		
Status: ☒ Not meeting target	Trend: Wait time is getting longer	
Formula: Weighted average time from referral until procedure is performed (weighted as 72% of neuro scan wait times, 15% of bone scan wait times, and 13% of body scan wait times).		
Description: Magnetic Resonance Imaging (MRI) is a special imaging technique used to image internal structures of the body, particularly the soft tissues. MRI uses a powerful magnet, radio frequency waves, and computers to produce detailed images of the body in any plane. It provides much greater contrast between the different soft tissues of the body than does computed tomography (CT), making it especially useful in neurological (brain), musculoskeletal, cardiovascular and oncological (cancer) imaging. The 3 types of MRI used to calculate the wait time are body, bone, and neurological. The wait time does not include those QEII patients who have elective MRI procedures performed at the IWK. The Department of Health has required weighting of the average by volume of procedures. The target wait time is 28 days.		
Analysis and Progress: During much of 2008, the average wait time for an elective MRI was longer than 200 days. This was due to staff shortages and the unavailability of trained MRI technologists across Canada. Throughout most of 2009, elective MRI average wait times shortened significantly and in November 2009 was 52 days. This was due to Capital Health investing in training 3 technologists which brought the staff complement back to funded levels. At the end of 2009 and into 2010, the wait time was lengthening. In July 2010, the wait time jumped up to 132 days as there was once again a vacancy (maternity leave) that management was unable to fill. Staff summer vacations also contributed to the longer waits. There was a resignation in October 2010 that remained unfilled until Capital Health was able to recruit a technologist in March 2011. On February 1st, 2012 an MRI technologist required surgery and will be off work for at least five months. And, once again, trained staff cannot be found to fill this vacancy. This highlights the overall shortage of trained MRI technologists. In April 2012, the average wait time for MRI was 229 days—over eight times longer than the target wait time of 28 days. To see recent wait times for elective MRI at locations in Nova Scotia click here.		
Source: Diagnostic Imaging	Frequency Tracked: Monthly	Last Updated: June 2012
Accountability: Paula Bond, David Barnes, Susan Delaney		Next Update Expected: July 2012

Wait Times & Patient Volumes for MRI at the QEII

April 2010 to April 2012



3.1.5 Wait Times - Radiotherapy Treatment

Strategic Stream: Person-Centered Health Care

Status: ☒ Not meeting target

Trends: Urgent radiotherapy waits hover around target; intermediate waits remain longer than target.

Formula: Wait time, in days, from date of referral to date of procedure. Values shown are the average wait times for a one-month period.

Description: In radiotherapy (also called radiation therapy), high-energy rays are used to damage cancer cells and stop them from growing and dividing. Target wait times for radiotherapy treatment are based on acuity level. Patients are assigned to an acuity level based on assessment by a radiation oncologist, a specialist in radiation therapy. Assessment criteria and target wait times for each acuity level are shown in the following table:

Acuity Level	Sample Assessment Criteria	Target Wait Time
Emergent	Acute superior vena cava obstruction, spinal cord compression or airway obstruction.	**24 hours**
Urgent	Subacute neurological dysfunction, tumor hemorrhage or severe, uncontrolled pain.	**7 days**
Intermediate	Children, inpatients in hospital for radiation services or having head and neck tumors.	**14 days**
Standard	Conditions of the T1 larynx, lymphoma, gastrointestinal tract, or central nervous system.	**21 days**

Analysis and Progress: The two graphs below show the average monthly wait times for patients in the urgent and intermediate categories. Patient volumes are also shown.

Wait times for *urgent* cases have been mostly hovering around the target of 7 days, but were only slightly over target for the months of January to April 2012.

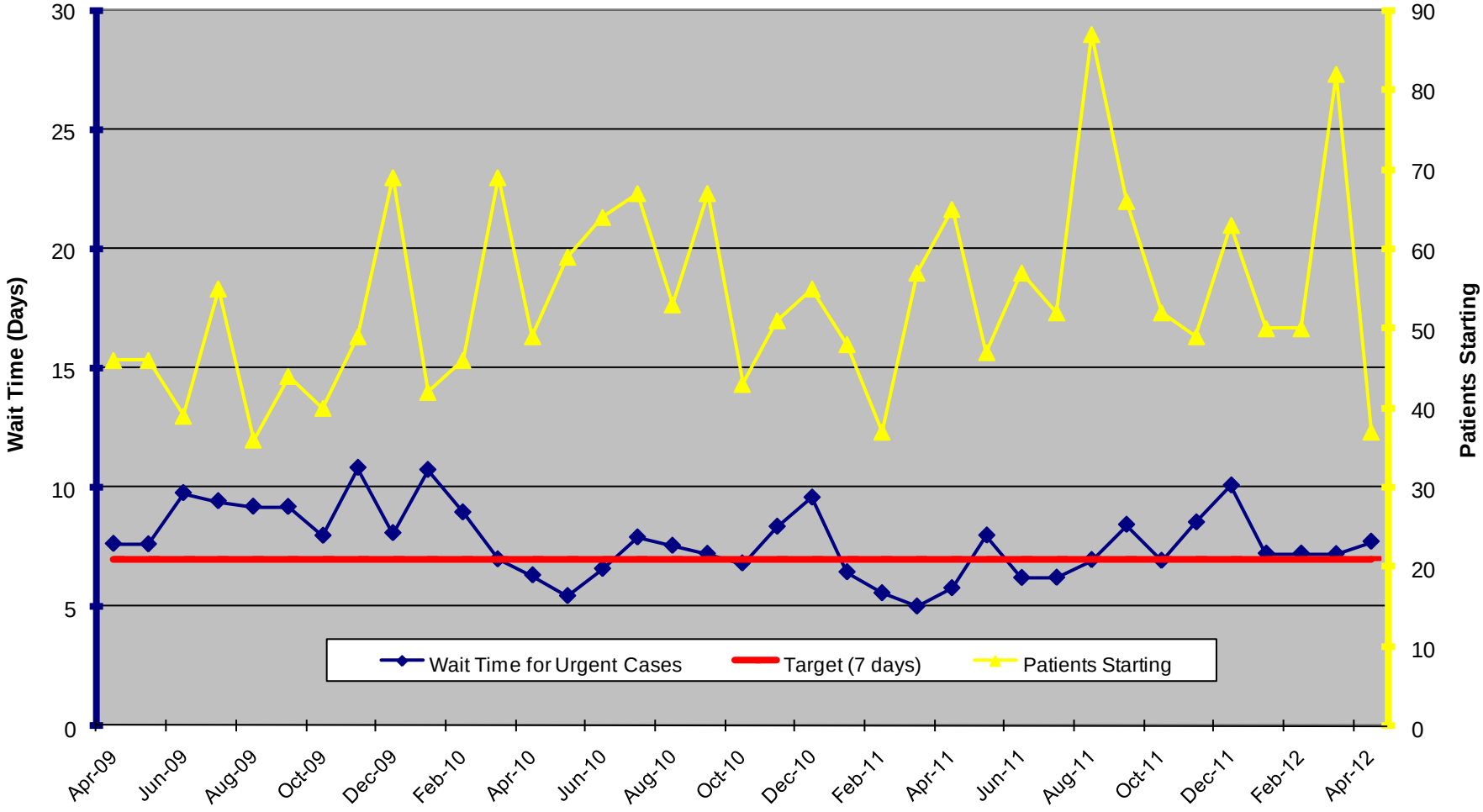
Wait times for *intermediate* cases have been consistently *longer* than the target of 14 days.

To see recent wait times for radiotherapy treatment at locations in Nova Scotia click here.

Data Source: Cancer Care Program Project Office	Frequency Tracked: Monthly	Last Updated: June 2012
Accountability: Paula Bond, Drew Bethune, Vickie Sullivan		Next Update Expected: July 2012

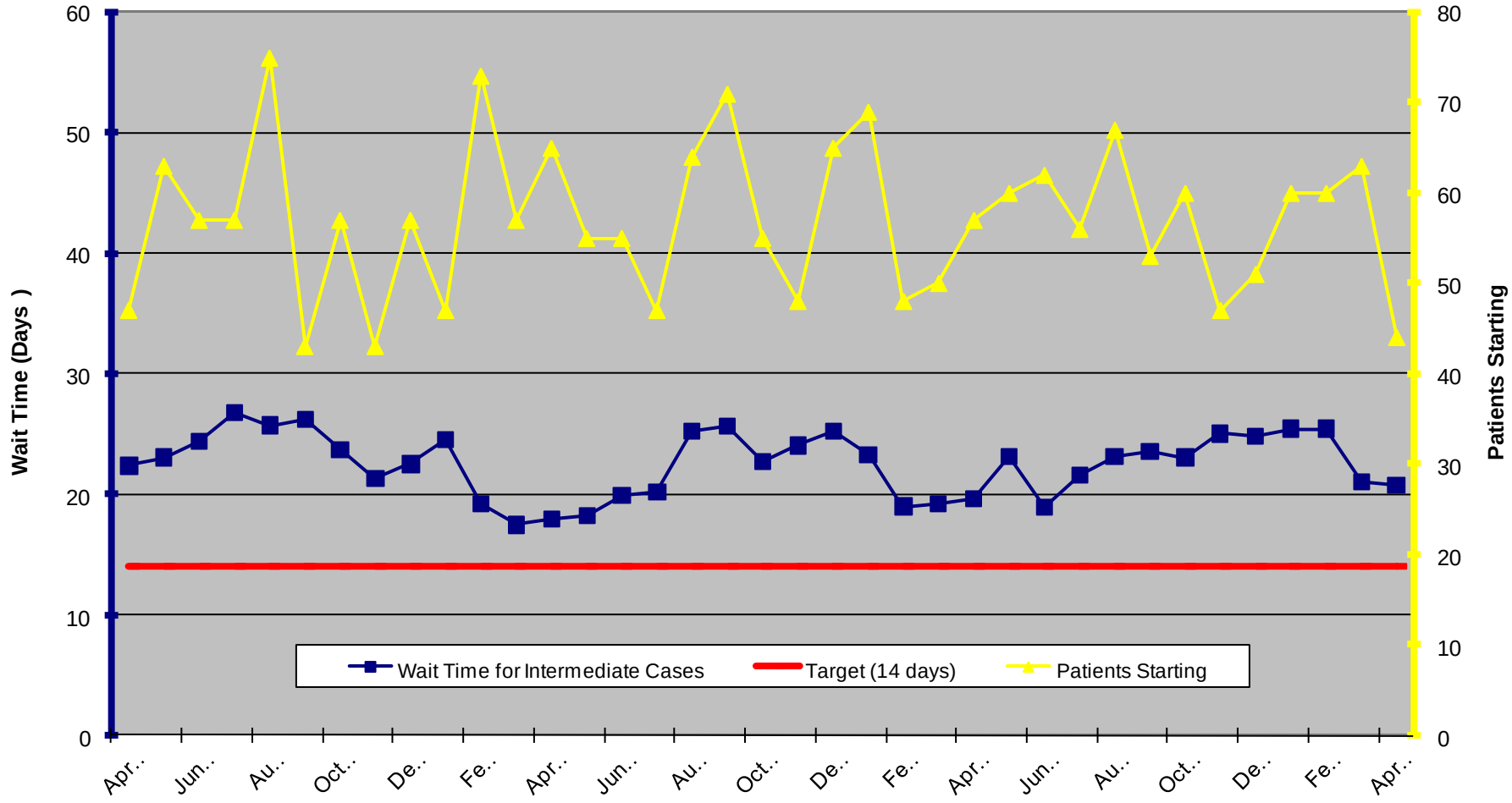
Wait Times and Patient Volumes for Radiotherapy Treatment - *Urgent*

April 2009 to April 2012



Wait Times and Patient Volumes for Radiotherapy Treatment - *Intermediate*

April 2009 to March 2012

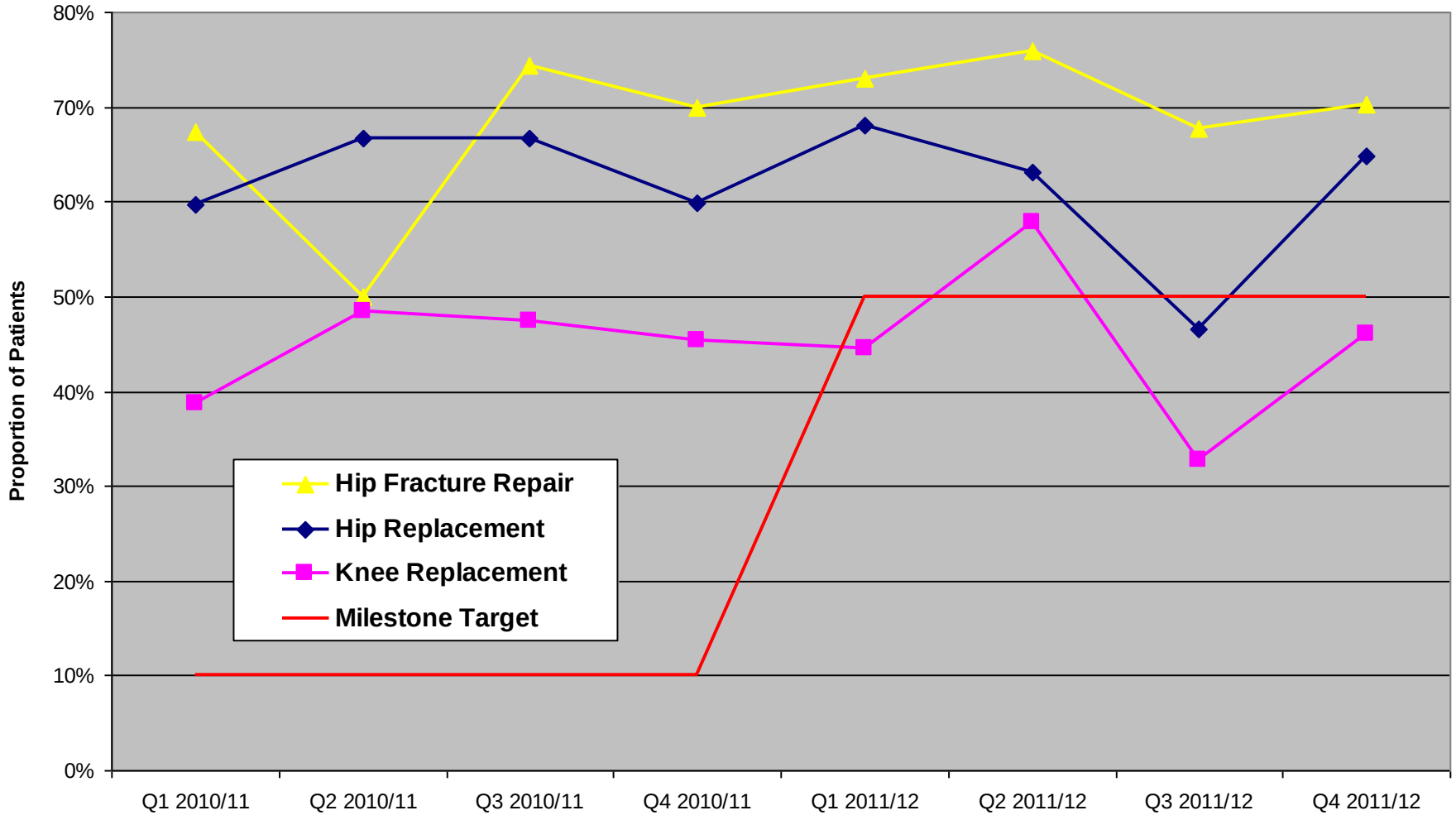


3.1.6 Wait Times – Orthopedic Surgery		
Strategic Stream: Person-Centered Health Care		
Status: ☑ Met the 2011/12 target for hip fracture repair and hip replacement ☒ Did not meet the 2011/12 target for knee replacement		Trend: See graph
Formula: The number of patients who had their procedure done in a given month who waited less than or the same as the national benchmark time frame, divided by the total number of patients who had the procedure completed in the same month, multiplied by 100.		
Description: Hip replacement is a surgical procedure in which the hip joint is replaced by a prosthetic implant. This is generally done to relieve arthritis pain or fix severe physical joint damage as part of hip fracture treatment. Knee replacement is a surgical procedure to replace the weight-bearing surfaces of the knee joint to relieve the pain and disability of osteoarthritis. It may be performed for other knee diseases such as rheumatoid arthritis and psoriatic arthritis. Hip fracture repair is a procedure to fix a fracture of the femur bone (thigh bone) near the hip joint. In the vast majority of cases, a hip fracture is a due to a fall or minor trauma in someone with weakened osteoporotic bone. Most hip fractures in people with normal bone are the result of high-energy trauma such as car accidents.[1] The nationally recognized target wait times for these procedures are: hip replacement: 26 weeks; knee replacement: 26 weeks; hip fracture repair: 48 hours. According to the *Our Promise: 2013 Milestones*, the goal is to increase the percentage of patients who have their surgical procedures within the target wait times to 10% by 2010/11, to 50% by 2011/12, and to 100% by 2012/13.		
Analysis and Progress: The graph below shows the quarterly percentages of patients who had their orthopedic procedures within the target wait times. A breakdown by procedure is shown. It can be seen that all three procedures were well above the target of 10% for 2010/11 (favorable). Hip replacements exceeded the target of 50% for 2011/12 with the exception of Q3. Knee replacements fell short of the 2011/12 target except in Q2. Hip fracture repairs exceeded the 2011/12 target of 50%. A joint initiative has been launched to increase the number of joint surgeries performed in a 10-hour OR theater from three to four. Actively pursuing completion of eight joints per day to be completed at the HI site. Currently 40% of days each week see eight joints completed per day. By September 2012, target 100% resulting in 40 joints per week or 1760 joints per year. An adhoc committee will regroup to examine the reason for the downward trend in fractured hip data. To see recent wait times for orthopedic surgeries in locations in Nova Scotia, click on the following links: knee replacement, hip replacement		
Data Source: PAR NS, Discharge Abstract Data	Frequency Tracked: Quarterly	Last Updated: May 2012
Accountability: Paula Bond		Next Update Expected: August 2012

[1] From the Wikipedia entries for "hip replacement", "knee replacement", and "hip fracture" accessed July 28, 2011

Percentage of Patients Who Waited Less Than or Equal to the National Benchmark Times for Orthopedic Procedures

Capital Health - Q1 2010/11 to Q4 2011/12



3.1.7 Wait Times – Cataract Surgery

Strategic Stream: Person-Centered Health Care

Status: ☑ Met the 2011/12 target	Trend: decreasing (unfavorable) but still meeting target

Formula: The number of patients who had their procedure done in a given quarter who waited less than or equal to the national benchmark time frame, divided by the total number of patients who had the procedure completed in the given month, multiplied by 100.

Description: Cataract surgery is the removal of a clouded lens (or cataract) from the eye to improve vision.

The nationally recognized benchmark wait time for cataract surgery is 16 weeks.

According to the *Our Promise: 2013 Milestones*, the goals are to increase the percentage of people who have their cataract surgery within the benchmark wait time to 10% by 2010/11, to 50% by 2011/12, and to 100% by 2012/13.

Analysis and Progress: The graph below shows the quarterly percentages of patients who had their cataract surgery within the benchmark wait time of 16 weeks. It can be seen that the target of 10% was met for 2010/11. More recently, the 50% target for 2011/12 was also met.

The waitlist for cataract surgery has grown by 9.7% over the past year. The demand is growing faster than the ability to complete procedures due to resource constraints.

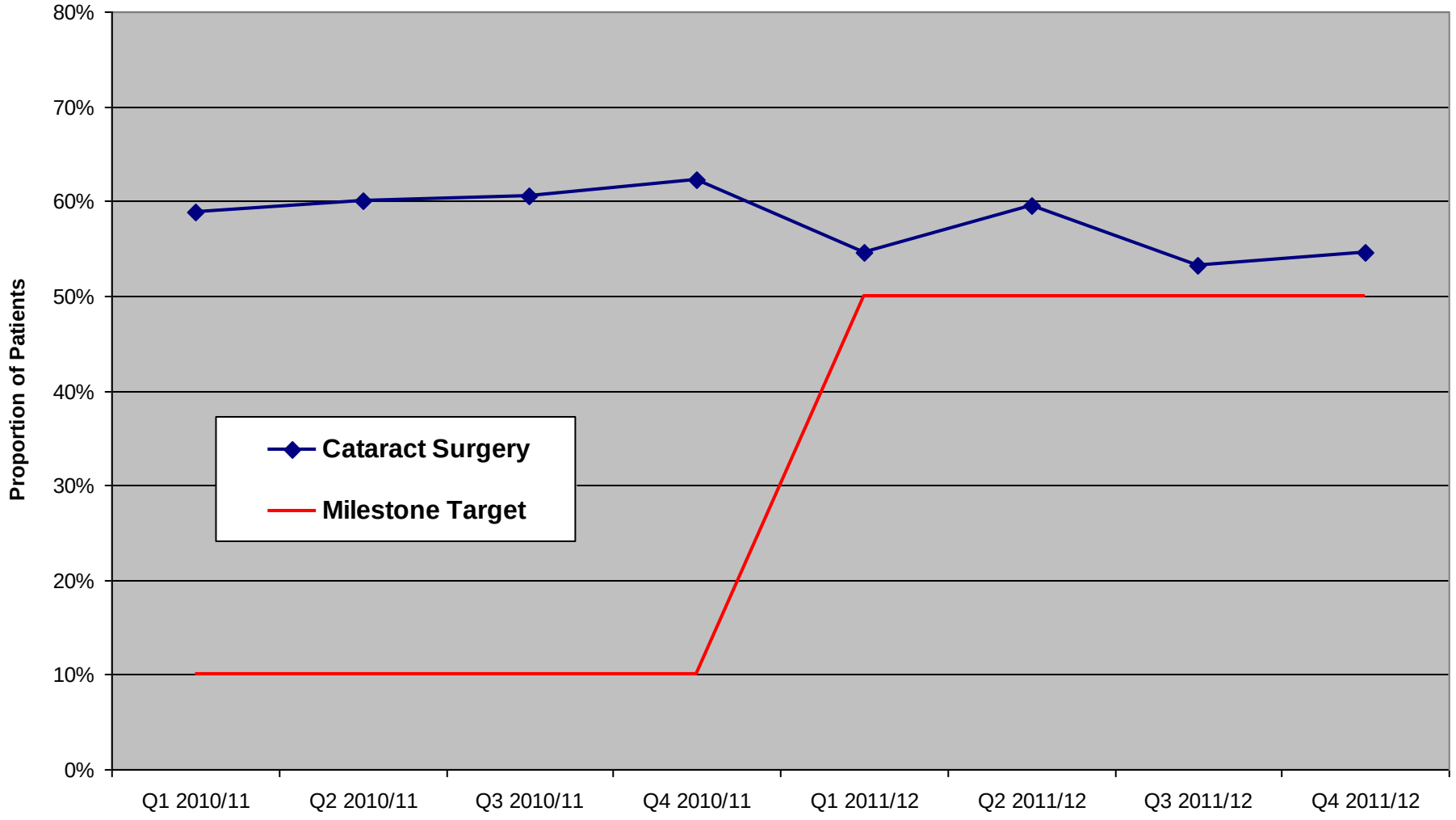
There are more than 2,400 patients waiting for cataract surgery at CDHA. Discussions are underway to look at the potential to do a blitz of cataract surgery to reduce wait times.

To see recent wait times for cataract surgery at different locations in Nova Scotia click here.

Data Source: PAR NS	Frequency Tracked: Quarterly	Last Updated: May 2012
Accountability: Paula Bond		Next Update Expected: August 2012

Percentage of Patients Who Waited Less Than or Equal to the National Benchmark Time for Cataract Surgery

Capital Health - Q1 2010/11 to Q4 2011/12

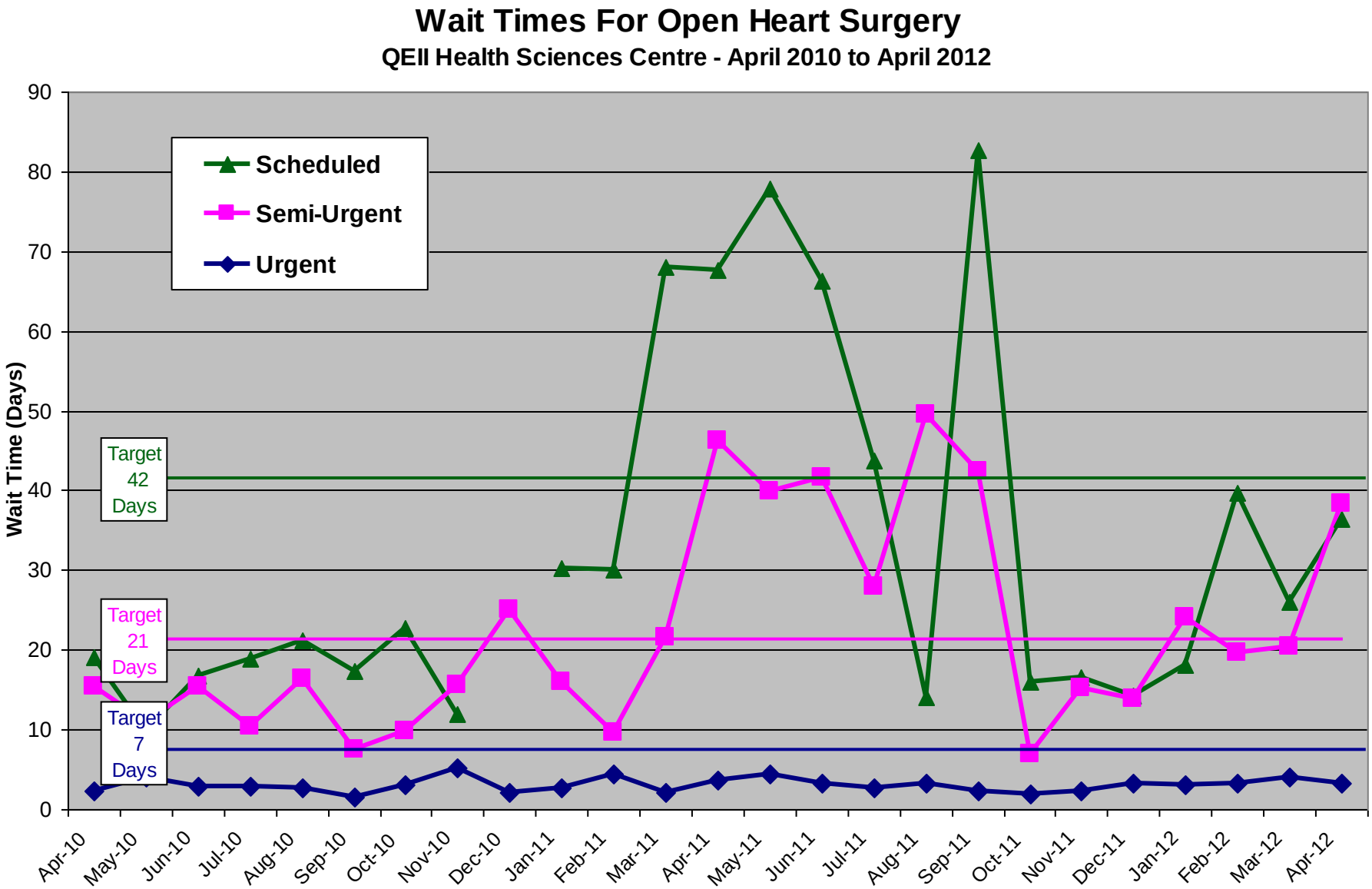


3.1.8 Wait Times – Other Surgeries

As of the October 2011 version of this report, some surgical wait time indicators have been temporarily removed. This is because the indicators are undergoing revisions. They will be returned when the revisions have been completed. This includes:

- coronary artery bypass graft surgery

3.1.9 Wait Times - Open Heart Surgery		
Strategic Stream: Person-Centered Health Care		
Status: ☑ Meeting target for urgent and scheduled ☒ Not meeting target for semi-urgent		Trend: See graph
Formula: Average wait time for open heart surgery procedures.		
Description: The graph below shows the average and target wait times for urgent, semi-urgent and scheduled open heart surgery procedures. Coronary artery bypass graft and valve replacements are included in the open heart surgery procedure grouping (previous versions of this report mentioned pacemaker insertions were included in this group, but this was incorrect). The targets for open heart surgery procedures are: ▪ Urgent – 7 days ▪ Semi-Urgent – 21 days ▪ Scheduled – 42 days		
Analysis and Progress: Wait Times for open heart surgery are shown in the graph below. For *urgent* cases, the average wait time has consistently remained under the seven-day target. The average wait time for *scheduled* cases has been shorter than the target for October 2011 to April 2012. *Semi-urgent* cases have had wait times that have been shorter than the target for the period October 2011 to December 2011, but were longer then target in January 2012. The wait time returned to below target for February and March 2012, but is over target again for April 2012. There is no average wait time measure for scheduled cases in December 2010 because no such procedures were performed during that time period.		
Source: Heart Health Program	Frequency Tracked: Monthly	Last Updated: June 2012
Accountability: Paula Bond, Karen MacRury-Sweet, Karen Mumford		Next Update Expected: July 2012


Wait Times For Open Heart Surgery
QEII Health Sciences Centre - April 2010 to April 2012
Wait Time (Days)
90
80
70
60
50
40
30
20
10
0
Scheduled
Semi-Urgent
Urgent
Target 42 Days
Target 21 Days
Target 7 Days
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12

3.1.10 Wait Times - Average Time from Triage to Physician in the Emergency Department

Strategic Stream: Person-Centered Health Care

Status: ☒ CTAS II-IV not meeting target
☑ CTAS V meeting target for all facilities except the DGH

Trend: See graphs and analysis

Formula: Average emergency department wait time from time of triage to time seen by a physician.

Description: A triage system is a method of assigning priorities to patients. The Canadian Triage & Acuity Scale (CTAS) is based on establishing a relationship between a group of sentinel events, which are defined by the ICD-9 diagnosis at discharge from the emergency department (or from an inpatient database) and the "usual" way these patients present. The triage scale is related to the time to be seen by a physician, as most decisions about investigation and initiation of treatment do not occur until the physician sees the patient or has the preliminary results to recommend a course of action.

The following is a brief description of each CTAS level along with target times*:

- CTAS Level I cases are Resuscitation – Threat to life – Target Time: immediate
- CTAS Level II cases are Emergent – Conditions are a potential threat to life – Target Time: 15 minutes
- CTAS Level III cases are Urgent – Conditions that could potentially progress to a serious problem – Target Time: 30 minutes
- CTAS Level IV cases are Less Urgent – Target Time: 1 hour
- CTAS Level V cases are Non-Urgent – Target Time: 2 hours

*Target times come from the Canadian Association of Emergency Physicians

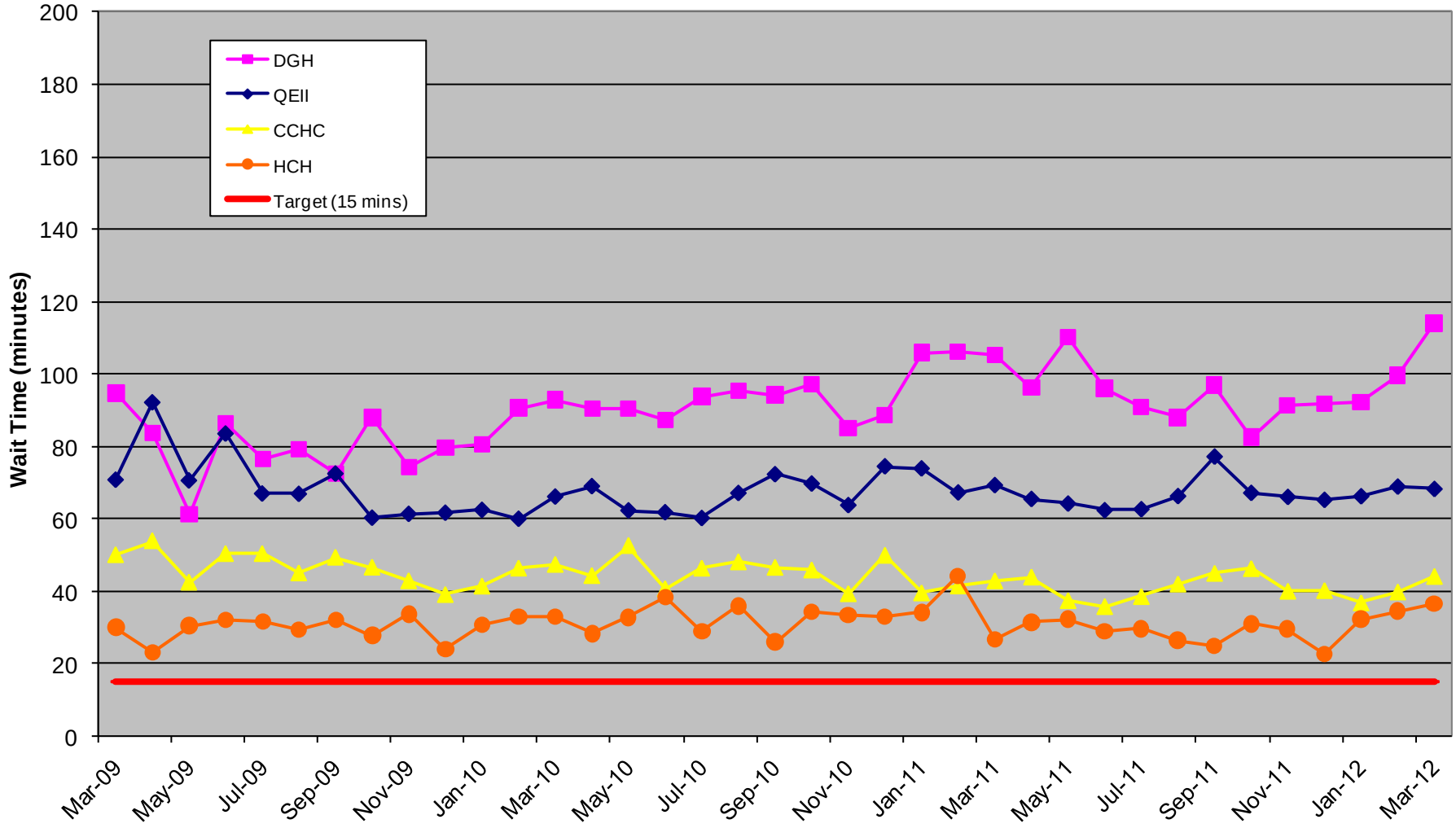
It should be noted, in some cases, certain patient work up is done at the time of triage or while the patient is in the waiting room and aspects of treatment can happen prior to being seen by a physician.

Analysis and Progress: The graphs below show the times from triage to physician for all CTAS Levels, except Level I (resuscitation). A breakdown by emergency department site is provided for each level. *CTAS Levels II through IV* all have wait times longer than the targets for all emergency departments. CTAS Level V has wait times *shorter* than the target of 2 hours for all facilities, with the exception of the DGH.

In January, two initiatives have started that will increase capacity within the Dartmouth ED: 1) expanded hours on the minor side. There was previously only staffing until 7:00 pm. Now it is staffed until 11:00 pm; and 2) trial period of a chair zone which will be staffed by an LPN- this will care for Level 4's & 5's or stable level 3's. This will be staffed 11:00 am to 7:00 pm.

Source: EDIS	Frequency Tracked: Monthly	Last Updated: May 2012
Accountability: Barbara Hall, Sandra Janes, David Petrie, Samuel Campbell		Next Update Expected: July 2012

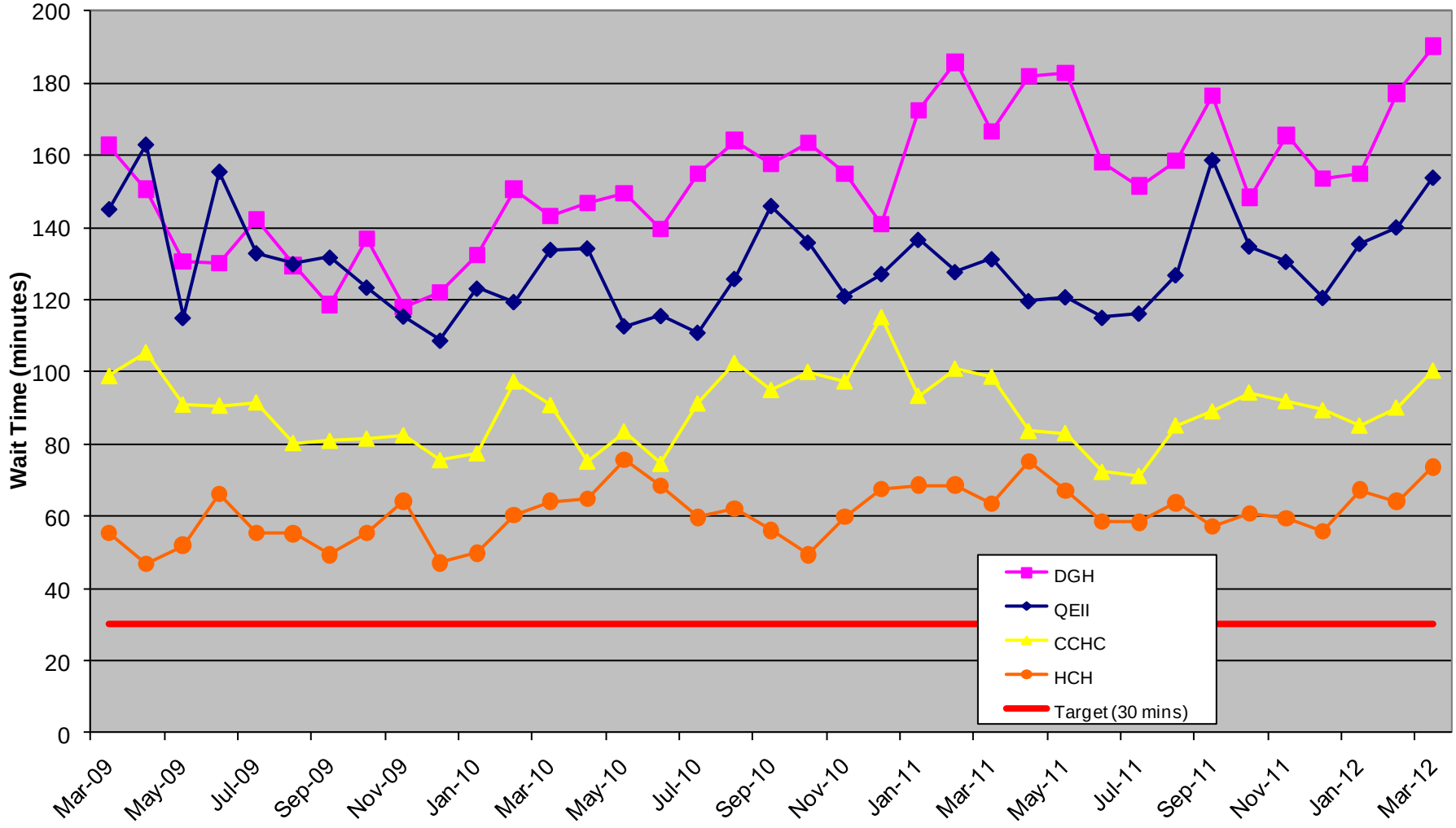
Average Emergency Wait Times
Triage to Physician - CTAS Level II
March 2009 to March 2012



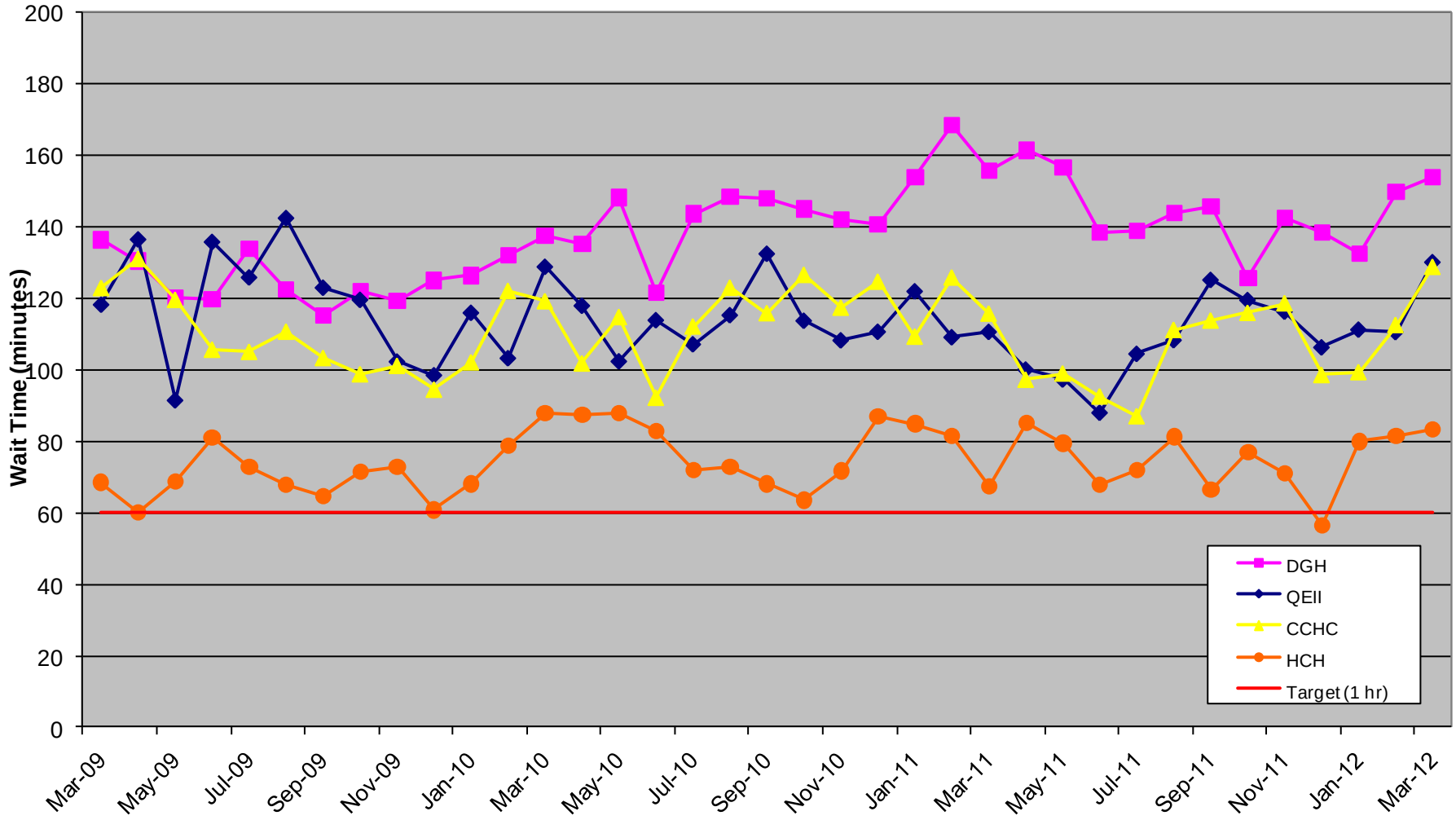
Average Emergency Wait Times

Triage to Physician - CTAS Level III

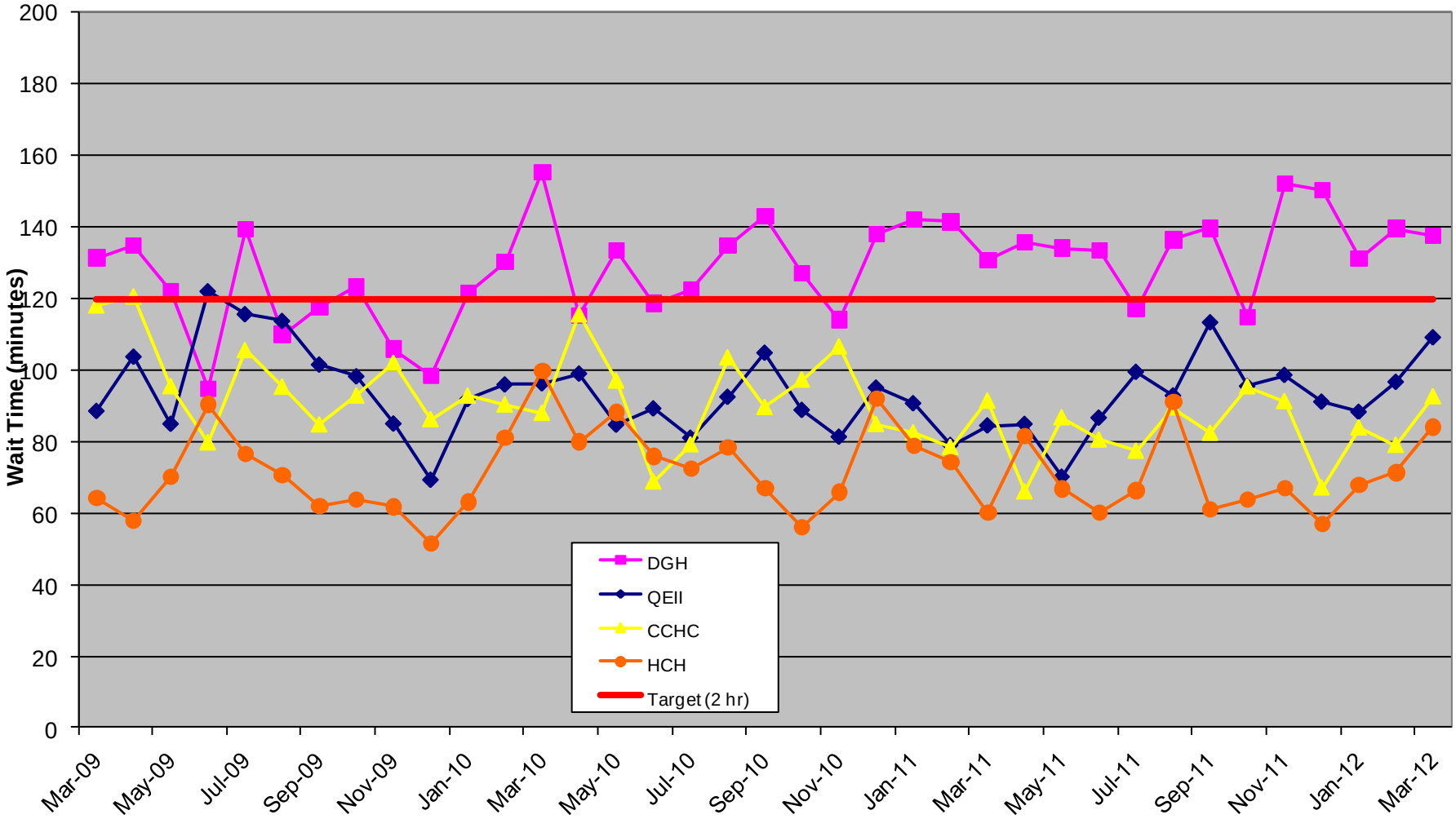
March 2009 to March 2012



Average Emergency Wait Times
Triage to Physician - CTAS Level IV
March 2009 to March 2012



Average Emergency Wait Times
Triage to Physician - CTAS Level V
March 2009 to March 2012



3.1.11 Patient Appointment No Show & Cancellation Rates		
Strategic Stream: Person-Centered Health Care		
Status: △ Caution – needs work to meet the 2011/12 target	Trend: No change	
Formulae: No shows: number of no show appointments divided by the number of scheduled appointments, multiplied by 100. Cancellations: number of cancelled appointments divided by the total number of scheduled appointments multiplied by 100. Rates are broken down by institution-related & patient-related reasons. Currently, the Department of Medicine excludes cancelled appointments from the denominator for no shows (see the definition on the following page).		
Description: Failed appointments have an adverse impact on treatment outcomes, clinic productivity, student learning experiences and resource utilization. Appointment cancellations are broken into two categories: patient-initiated and service-initiated. Both need to be addressed to reduce waste. Appointment no shows are missed appointments with no prior communication from the patient. The goal of this milestone work is to address both. This Milestone is meant to apply to all ambulatory care areas. Capital Health's Our Promise Milestone target is to decrease patient appointment no shows and cancellation rates by 25% in 2010/11, 35% by 2011/12, and reaching 50% by 2012/13.		
Analysis and Progress: This information is entered into PHS by booking clerks for all clinics on the 4th floor of the HI site. This information is presently reported for medicine but not surgery or orthopedic clinics. The DOM has a dedicated IT person who monitors the data to ensure accuracy, cleans the data and then extracts this information for a quarterly report. Sample data from the Department of Medicine and Mental Health are presented below.		
Source: Decision Support	Frequency Tracked: Quarterly	Last Updated: January 2012
Accountability: Paula Bond		Next Update Expected: July 2012

No Shows and Cancellations – Sample Data

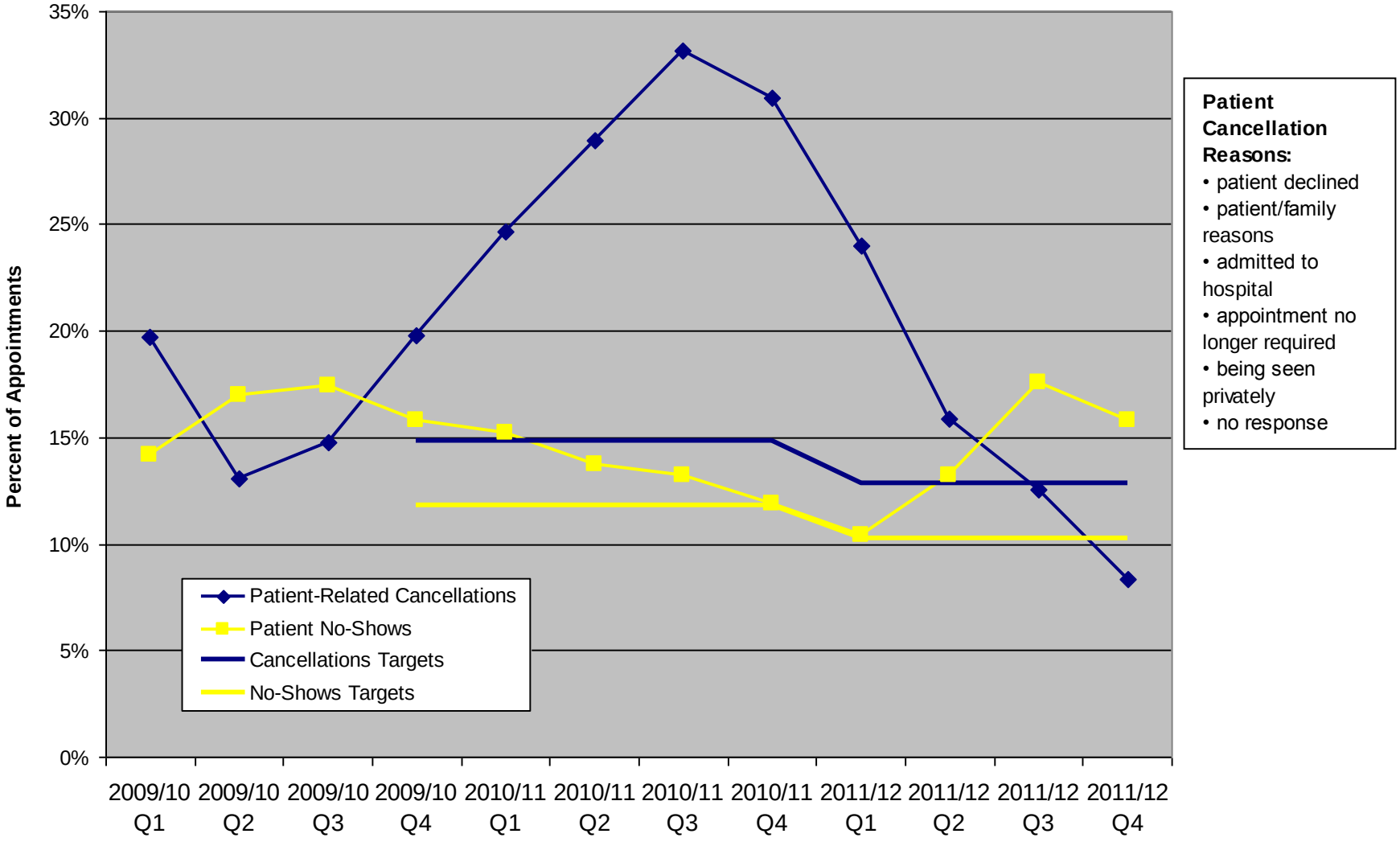
To highlight some of the leading work already done in this area, graphs of no shows and cancellations for the Department of Medicine and for Mental Health are shown below. Note the results for the two departments are not directly comparable due to differences in the methods of data collection and reporting.

For **Mental Health Community Teams**, no shows and cancellations are calculated as the number of no shows or cancellations for new appointments divided by the total number of scheduled new appointments, multiplied by 100. Only patient-related cancellations are counted. Cancellations due to resource-related reasons, such as unavailability of a practitioner, are considered rescheduled rather than cancelled and so are not reported. Results shown are for all community teams combined. The New First Visit/Service Access initiative for the Community Mental Health Teams was put in place May 1, 2011, which changed the service access process and therefore may contribute to a difference in the no shows and cancellations from that point on.

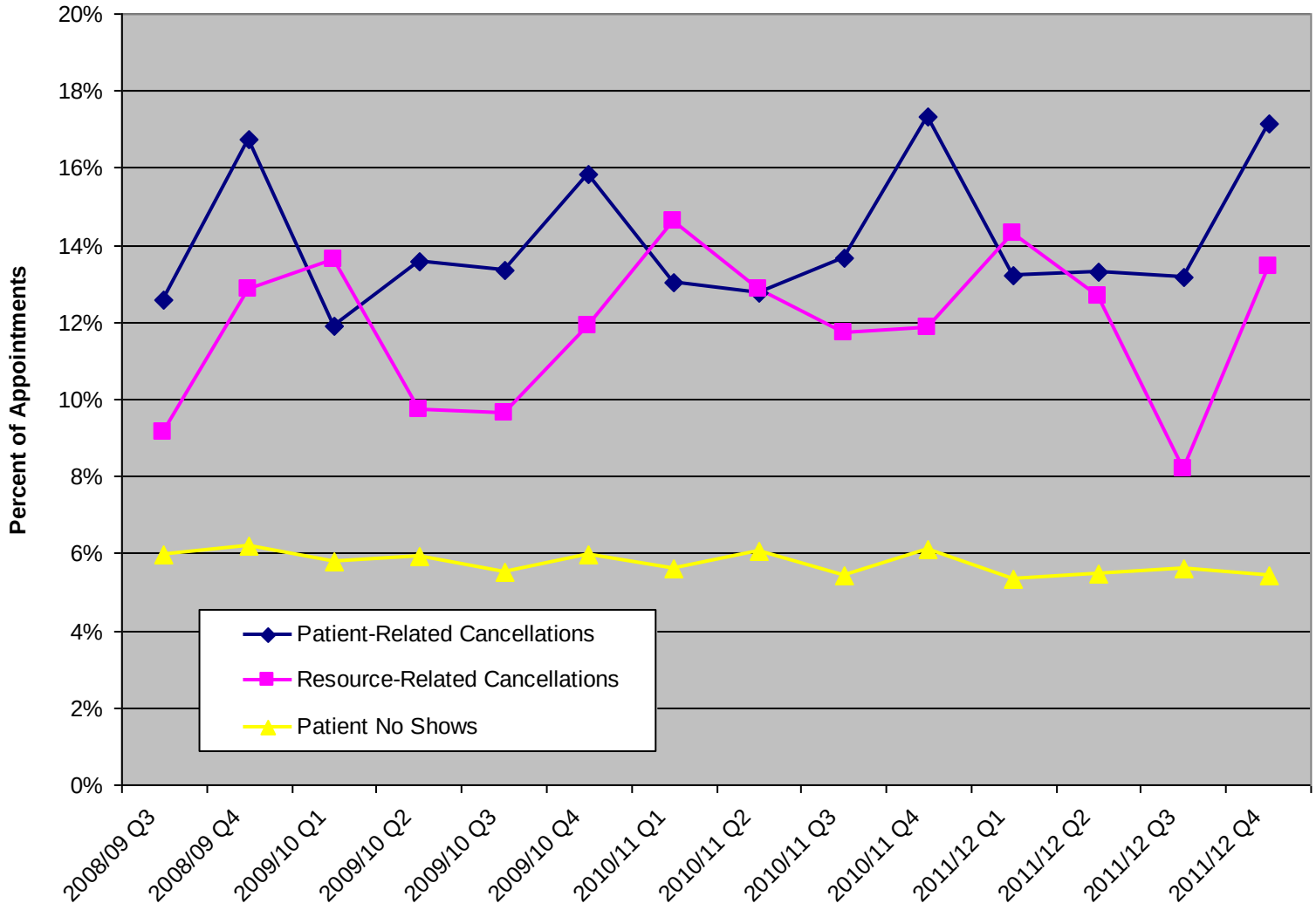
In the **Department of Medicine**, cancellations are calculated as the number of cancelled visits divided by the number of attended appointments and cancellations and no shows (total booked appointments), multiplied by 100. Cancellations also include rescheduled appointments. Patient-related cancellations and resource-related cancellations are reported separately. No shows are calculated as the number of no shows divided by the number of attended appointments and no shows. Cancellations are excluded from the denominator. No shows and cancellations have been collected from patient appointments for any physician who is actively part of the Department of Medicine. Strict reconciliations are completed each day for no show and cancellation data for any clinic location under a Department of Medicine Manager. If a Department of Medicine physician sees patients at a location outside these locations, the data may not undergo the same scrutiny.

Patient and resource-related reasons used in Mental Health and in the Department of Medicine are shown alongside the respective graphs below. The graphs were last updated in May 2012. The next update is expected in the August 2012 version of this report.

Mental Health New Appointment No Shows & Cancellations By Quarter from 2009/10 Q1 to 2011/12 Q4



Department of Medicine Appointment No Shows & Cancellations By Quarter from 2008/09 Q3 to 2011/12 Q4



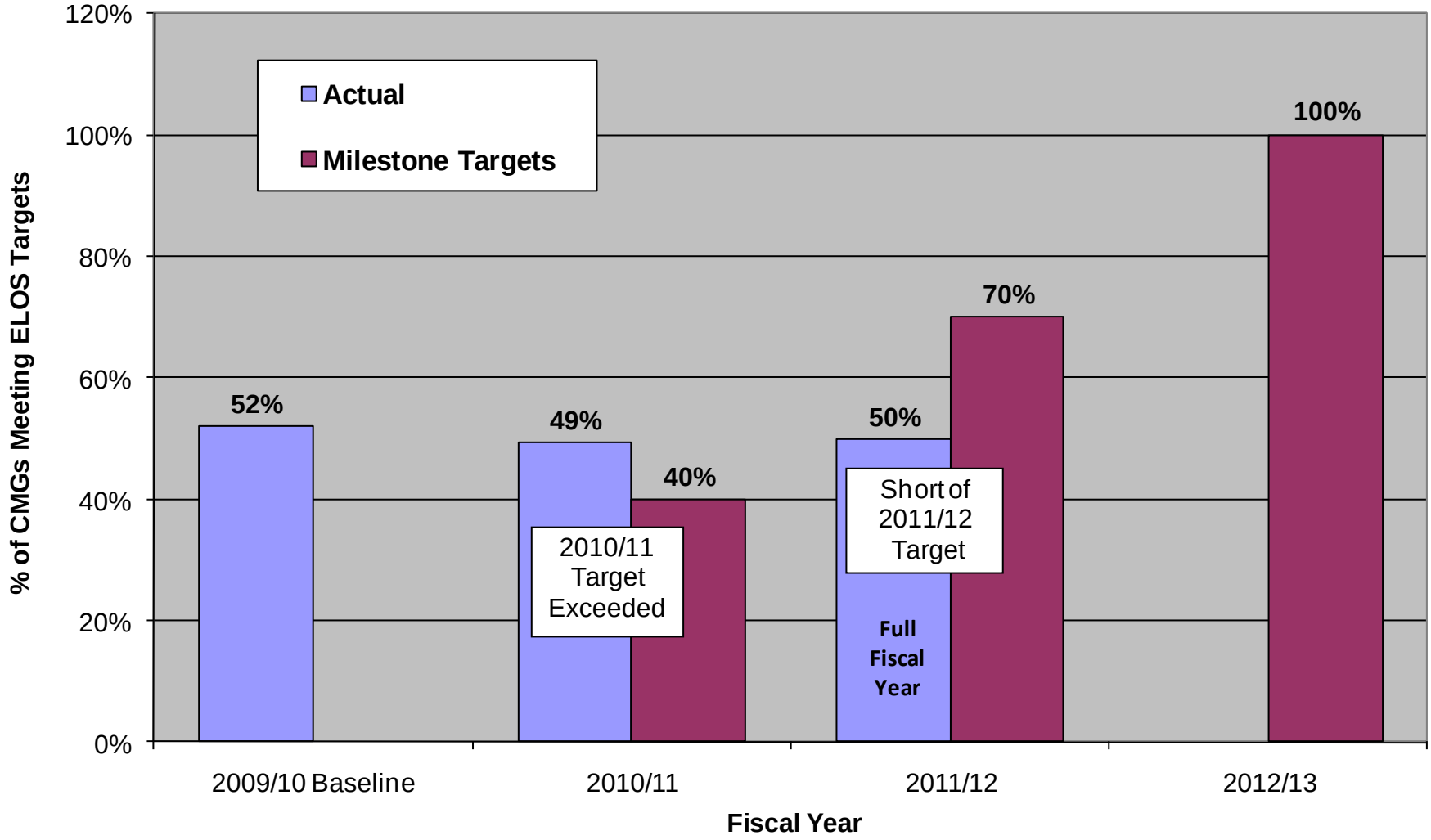
Patient-Related Reasons:
- coordinating multiple appointments
- feeling better/worse
- work
- weather concerns
- transportation
- financial
- emergencies
- the patient feels the appointment is no .

Resource-Related Reasons:
- practitioner unavailable
- patient admitted to hospital
- facility unavailable
- waiting for test results
- referral redirected to community physician
- written advice provided to the referring physician regarding care for the patient

3.1.12 Length of Stay - Percentage of Case Mix Groups Meeting Expected Length of Stay Target		
Strategic Stream: Person-Centered Health Care		
Status: ☒ Not meeting the 2011/12 target	Trend: Slight increase from previous year.	
Formula: The number of case mix groups (CMGs) for which the average length of stay (ALOS) is equal to or less than the expected length of stay (ELOS) divided by the total number of CMGs (typical cases only).		
Description: The percent of CMGs meeting the ELOS target includes typical cases only. All cases are considered typical *except* patients who sign themselves out against medical advice, patients who transfer to or from another acute care facility, patients with long stays, and deaths. The Our Promise Milestone goals are to have the ALOS meet the ELOS for 40% of CMGs by 2010/11, for 70% of CMGs by 2011/12, and for 100% of CMGs by 2012/13. The baseline year is 2009/10. The goal is to accomplish these targets without increasing readmission rates. Readmissions include patients readmitted to hospital within 28 days of discharge and patients admitted within 7 days of day surgery. This indicator includes QEII, DGH, HCH, NSH, ECFH and the Tri-facilities.		
Analysis and Progress: The graph below shows the percent of CMGs that meet the ELOS targets. For the baseline year 2009/10, **52%** of CMGs (253 of 487 CMGs) had an ALOS that was less than or equal to the ELOS (53.3% of individual cases). This was on par with the percent of CMGs for the previous two years. In 2010/11, 49% of CMGs (236 out of 479 CMGs) had an ALOS that was less than or equal to the ELOS (47% of individual cases). The 2010/11 target was met. In 2011/12, **50%** of CMGs had an ALOS less than or equal to the ELOS (244 out of 490 CMGs; 48% of individual cases). This is short of the 2011/12 target of 70%. In the 2009/10 baseline year, the readmission rate was 6.3% (typical cases only). In 2010/11, the readmission rate was 6.8%—an increase of 0.5% over the baseline year. For 2011/12, the readmission rate was 6.4%.		
Source: Discharge Abstract Database	Frequency Tracked: Monthly	Last Updated: June 2012
Accountability: Paula Bond		Next Update Expected: July 2012

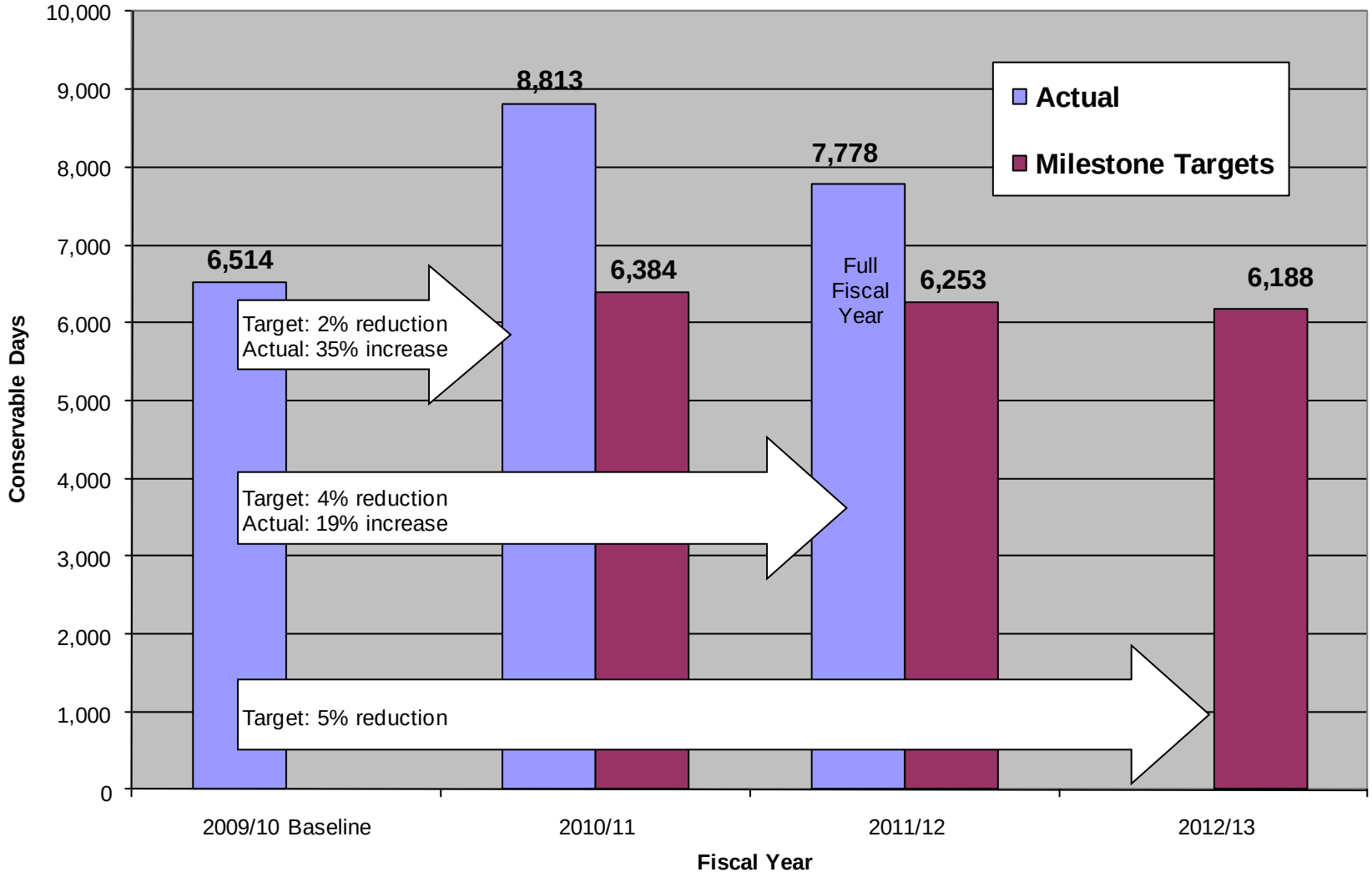
Percentage of CMGs Meeting ELOS Targets at CDHA

2009/10 to 2011/12 and Milestone Targets (Typical Cases Only)



3.1.13 Length of Stay - Number of Conservable Days		
Strategic Stream: Person-Centered Health Care		
Status: ☑ On track to meet 2011/12 target	Trend: see graphs	
Formula: Average length of stay (ALOS) minus the expected length of stay (ELOS) multiplied by the total number of cases.		
Description: The target for the 2010/11 fiscal year is a reduction of 2% from the 2009/10 baseline year. The target for 2011/12 is a reduction of 4% and the target for 2012/13 is a reduction of 5%.		
Analysis and Progress: Conservable days for typical cases are shown in the graph below. To meet the 2010/11 target, conservable days needed to decrease by at least 2%. In 2010/11, conservable days *increased* by 35%. To meet the 2011/12 target, conservable days need to decrease by 4%. The result was there was an *increase* of 19% from the 2009/10 baseline. This is an improvement over 2010/11, but is still short of the 2011/12 target. It should be noted that variation from year to year can occur not only as a result of changes in the *average* lengths of stay but also as a result of year-to-year adjustments in *expected* lengths of stay, as determined by the Canadian Institute for Health Information. As an example, if the expected length of stay decreases for a given case mix group, the conservable days for a given facility can increase despite the average length of stay remaining unchanged.		
Source: Discharge Abstract Database	Frequency Tracked: Monthly	Last Updated: June 2012
Accountability: Paula Bond		Next Update Expected: July 2012

Conservable Days for *Typical Cases* at CDHA
2007/08 to 2011/12 and Milestone Targets



3.1.14 Length of Stay - Average Length of Stay and Expected Length of Stay Comparison

Strategic Stream: Person-Centered Health Care

Status: ☒ Not meeting target	Trend: Difference is decreasing

Formula: Average length of stay (ALOS) compared to expected length of stay (ELOS) (typical cases only).

Description: ALOS compared to ELOS for the past three fiscal years. Data includes typical cases only. Lengths of stay are measured in days.

The ALOS target is to reach the ELOS for typical cases (ALOS minus ELOS is less than or equal to zero).

Typical cases include all patients except the following:

- Patients who sign themselves out against medical advice
- Patients who transfer to or from another acute care facility
- Patients with long stays
- Deaths

Includes QEII, DGH, HCH, NSH, ECFH and the Tri-facilities.

Analysis and Progress: The ALOS and ELOS, as well as total cases for recent fiscal years, are shown in the table below.

For fiscal year 2011/12, ALOS and ELOS have both decreased from the 2010/11 values, and the difference has decreased to 0.3 days; however, this difference is the same as it was in 2008/09 and 2009/10.

Source: Discharge Abstract Database	Frequency Tracked: Monthly	Last Updated: June 2012
Accountability: Paula Bond		Next Update Expected: July 2012

Average Length of Stay and Expected Length of Stay Comparison for Capital Health *(Typical Cases Only)*

Fiscal Year	Total Cases	ALOS (days)	ELOS (days)	Difference (ALOS – ELOS)
2007/08	23,867	6.7	6.5	0.2
2008/09	24,169	6.4	6.1	0.3
2009/10	24,024	6.3	6.0	0.3
2010/11	23,651	6.4	6.0	0.4
2011/12	23,515	6.2	5.9	0.3

3.1.15 Occupancy Rates

Strategic Stream: Person-Centered Health Care

Status: ☒ Did not meet the 2011/12 target	Trend: The total occupancy rates for QEII and DGH were above the 2011/12 target of 91%.

Formula: Occupancy rate is patient days (census days) divided by available hospital days, multiplied by 100. Total occupancy rates do not include long term care/transitional care. This is because the occupancy rate target for long term care is 99% which differs from the milestone target occupancy rates.

Description: Occupancy rate is used to show the actual utilization of the hospital for a given period of time and has a direct affect on inpatient and emergency department flow. Occupancy rates are also calculated for individual units and services. It is important to accurately record the number of available hospital beds in order to calculate the occupancy rate. The following is a sample calculation:

Occupancy Rate = (Patient Days (census) / Available Hospital Days) x 100 = (27,078 / 28,654) x 100 = 94.5%

Capital Health's Our Promise Milestone targets are to decrease the occupancy rate to 92% by 2010/11, to 91% by 2011/12, and to 90% by 2012/13.

Analysis and Progress: The graphs below show the yearly occupancy rates for services at the QEII and the Dartmouth General. The *total* occupancy rates for each of the QEII and the DGH were above the 2010/11 target of 92% (unfavorable). The following services were below the 2010/11 target of 92% (favorable) for 2010/11: QEII Surgical, QEII ICU, and DGH ICU/CCU. All other services were above the target (unfavourable).

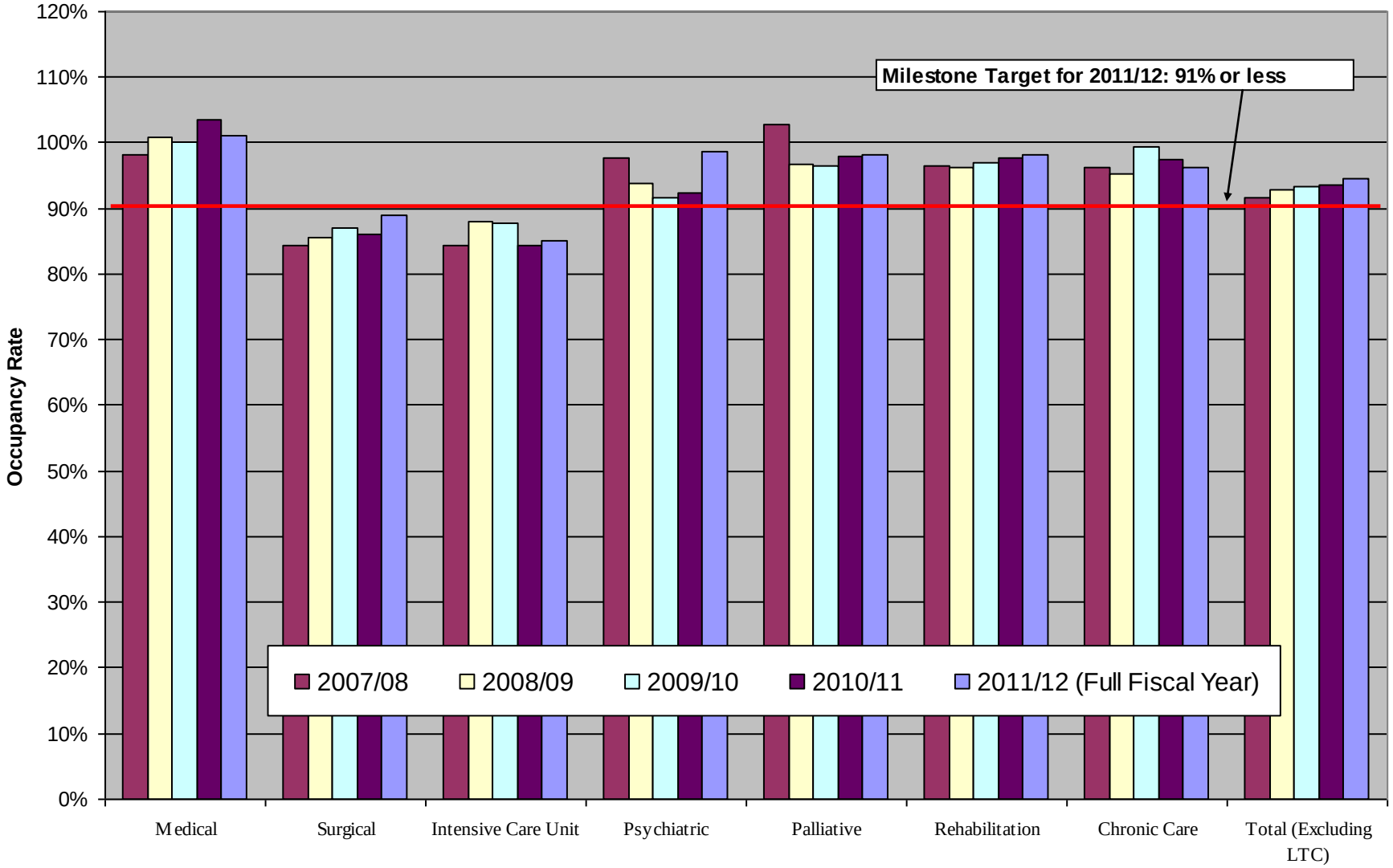
In 2011/12, the same services exceeded the target of 91%; however, the totals for the DGH and the QEII are still above this target (unfavourable).

It should be noted the occupancy rates for QEII psychiatry from 2007 to 2010 are an underestimate because they had four beds that were listed as "open" in the STAR system, but weren't actually available for use. An estimated correction would put all the psychiatry occupancy rates higher than the 92% target for these time periods. The bed counts were corrected in STAR in January 2011 and so occupancy rates for psychiatry after this date reflect the true situation on the service.

Source: STAR	Frequency Tracked: Monthly	Last Updated: May 2012
Accountability: Paula Bond		Next Update Expected: July 2012

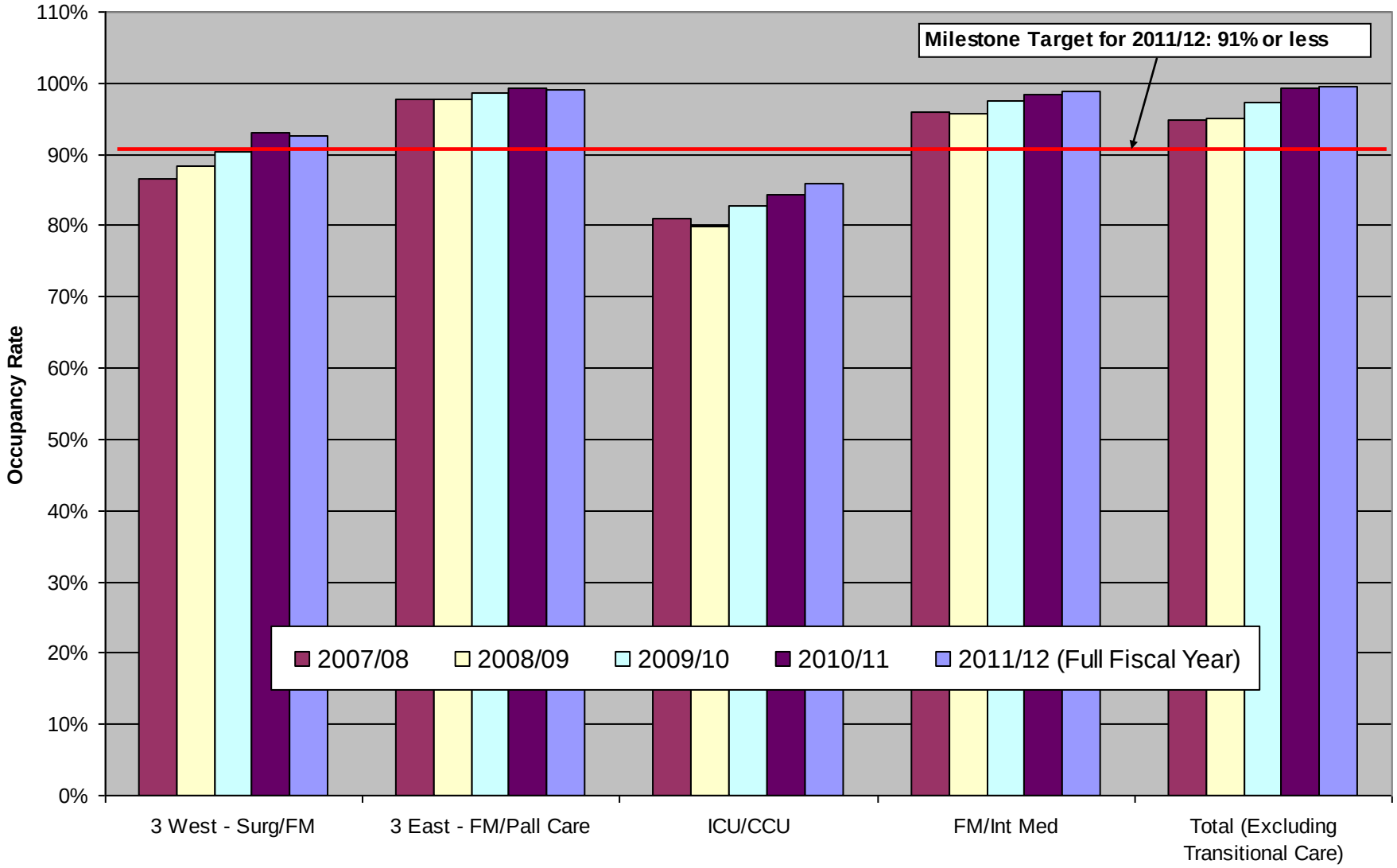
QEII Service Occupancy Rates

Fiscal Years 2007/08 to 2011/12



DGH Occupancy Rates

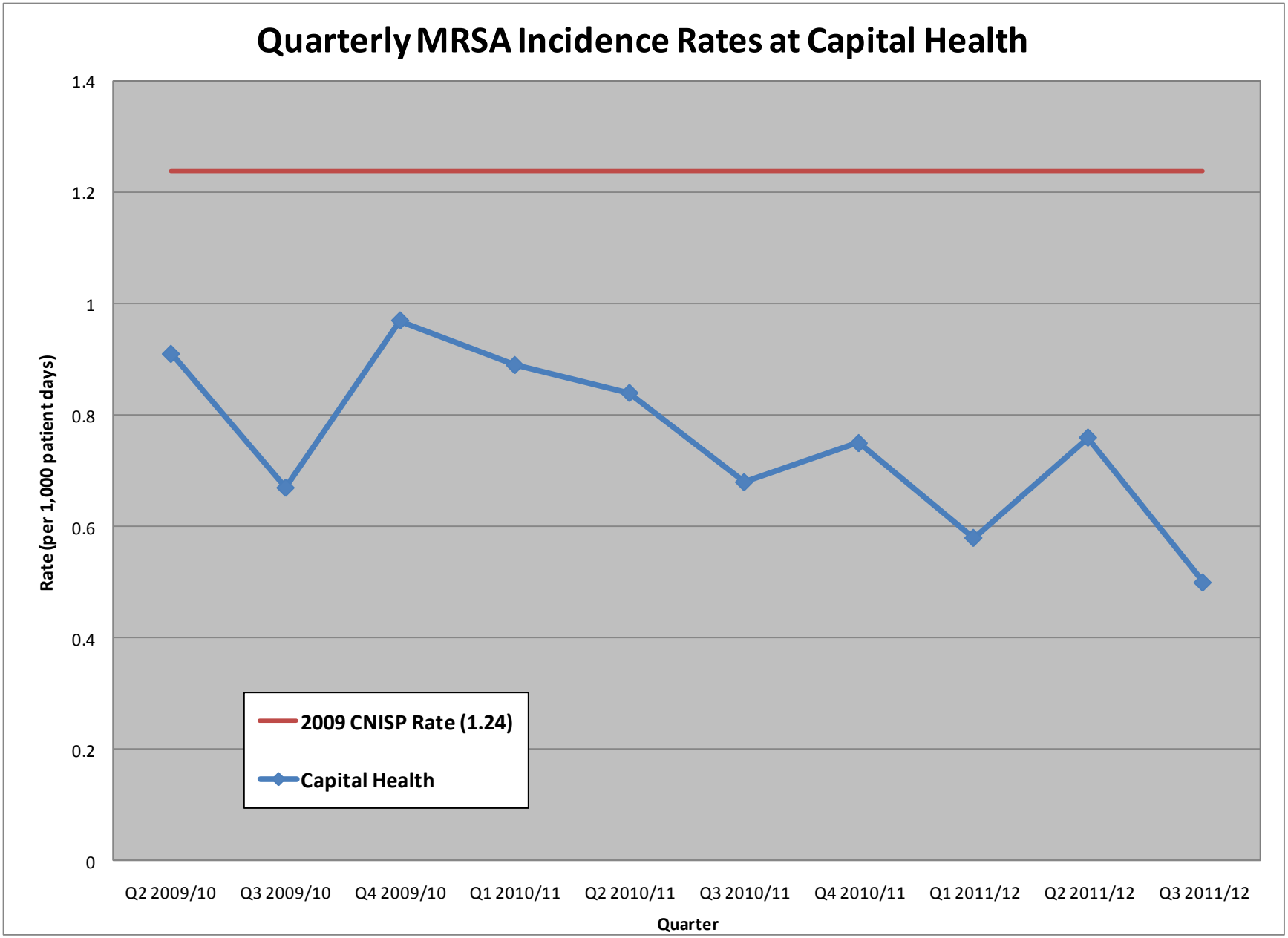
Fiscal Years 2007/08 to 2011/12



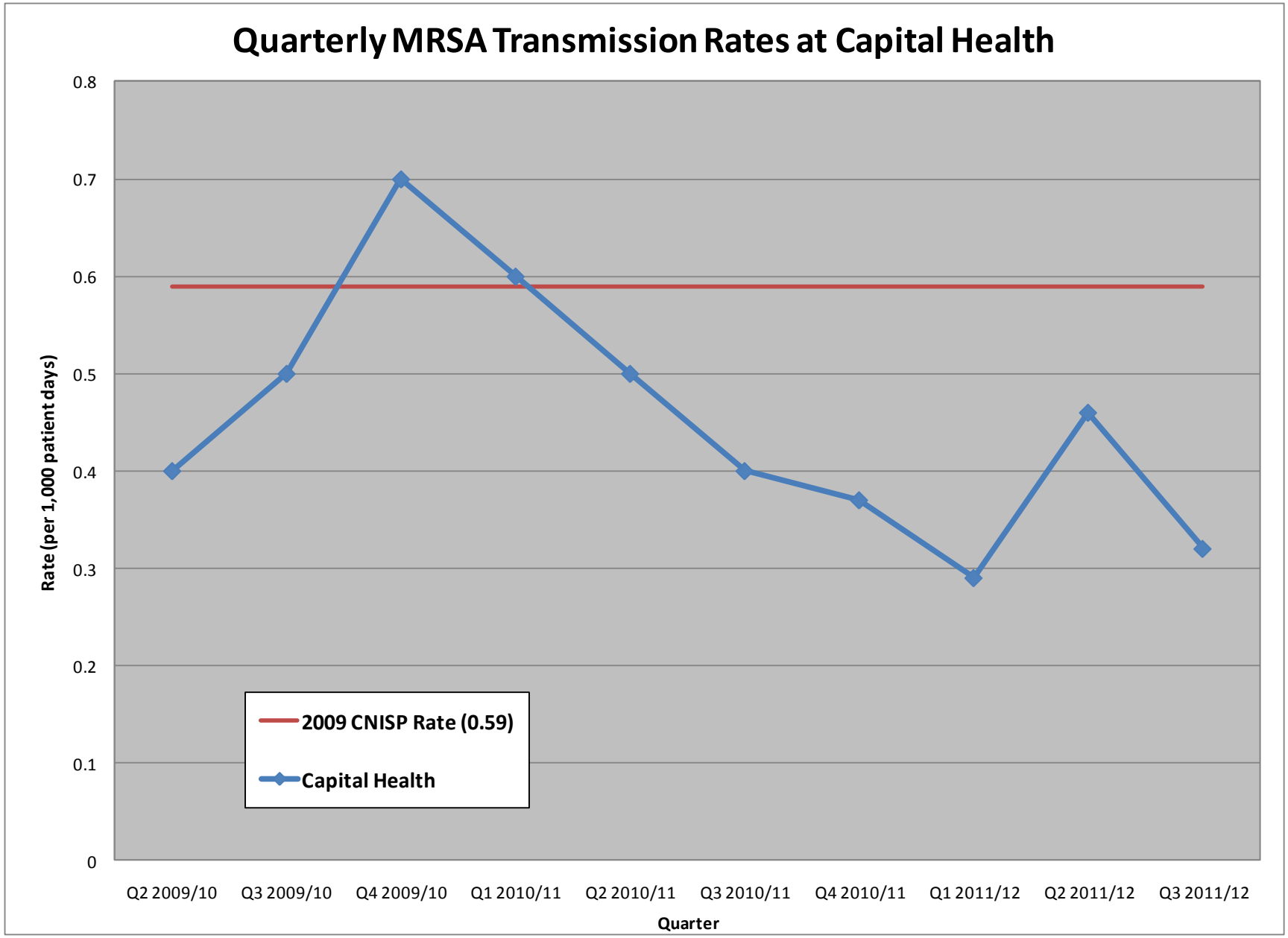
3.1.16 Incidence and Transmission Rates - MRSA	**Patient Safety Indicator**
Strategic Stream: Person-Centered Health Care	
Status: ☑ Meeting targets	Trend: decreasing
Formula: Total cases of MRSA divided by the total patient days multiplied by 1,000 (for a per 1,000 patient days rate). **Note: as of the June 2012 version of this report, the rates have been changed from per 1,000 *admissions* to per 1,000 *patient days*.**	
Description: Methicillin-resistant *Staphylococcus aureus* (MRSA) and vancomycin-resistant enterococcus (VRE) are two of the most significant antibiotic-resistant organisms that can cause healthcare-associated infections. If an infection occurs, antibiotic treatment choices are limited and the infection may be more difficult to treat. In the health care setting, the primary modes of MRSA transmission are the unwashed hands of caregivers, breaches in isolation precautions, and patient contact with contaminated and improperly cleaned communal equipment. MRSA is not airborne. MRSA does not cause one specific type of infection, but it may cause a variety of infections such as pneumonia, surgical wound infection, and urinary tract infection. Patients who have MSRA are cared for in strict isolation—in a single room, and with dedicated equipment not used for other patients. Careful hand hygiene before and after contact with the positive patient or their environment is one of the most important control measures for health care providers in preventing MRSA transmission. The surveillance for these incidence and transmission rates includes the HI, VG, 9 Abbie Lane, VMB 3 East, and the Rehabilitation Centre, with the exception of 2010 & 2011 which also includes the Dartmouth General and Hants Community Hospitals (Haliburton Place excluded). Infections are those cases that are *identified* at the hospital while transmissions are those cases that are *acquired* while in hospital.	
Analysis and Progress: A summary of quarterly MRSA incidence and transmission rates can be seen in the two graphs below. In 2009, according to the Canadian Nosocomial Infection Surveillance Program of the Public Health Agency of Canada, the national MRSA *incidence rate* was 1.24 per 1,000 patient days and the national *transmission rate* was 0.59 per 1,000 patient days. In 2010/11 and the first three quarters of 2011/12, the incidence rates were below the 2009 national rate. The transmission rates were below the 2009 national rate for the last three quarters of 2010/11 and the first three quarters of 2011/12.	

Source: Infection Control	Frequency Tracked: Quarterly	Last Updated: June 2012
Accountability: Catherine Gaulton, Mary Ellen Gurnham, Lynn Johnston		Next Update Expected: September 2012

Note: as of the June 2012 version of this report, the rates have been changed from per 1,000 *admissions* to per 1,000 *patient days*.



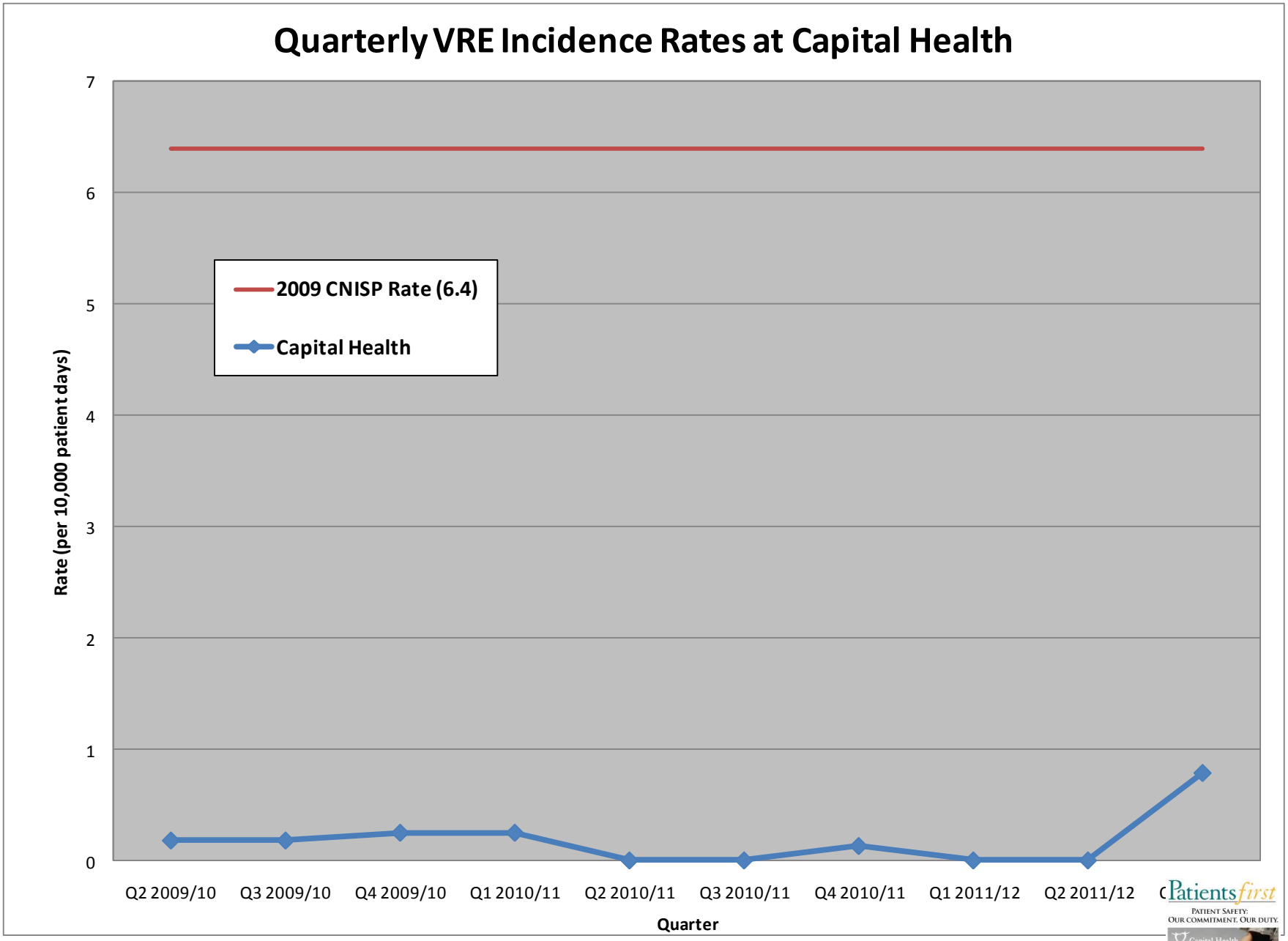
Note: as of the June 2012 version of this report, the rates have been changed from per 1,000 *admissions* to per 1,000 *patient days*.



3.1.17 Incidence Rate - VRE	**Patient Safety Indicator**
Strategic Stream: Person-Centered Health Care	
Status: ☑ Meeting target	Trend: Well below national rate but increasing.
Formula: The number of cases of VRE divided by total patient days, multiplied by 1,000 to get a rate per 1,000 patient days. **Note: as of the June 2012 version of this report, the rates have been changed from per 1,000 *admissions* to per 1,000 *patient days*.**	
Description: Methicillin-resistant *Staphylococcus aureus* (MRSA) and vancomycin resistant enterococcus (VRE) are two of the most significant antibiotic-resistant organisms that may cause healthcare-associated infections. If an infection occurs, antibiotic treatment choices are limited and the infection can be more difficult to treat. In eastern Canada, the VRE rate continues to be lower than in central and western Canada. VRE is spread in health care settings primarily by the hands of health care workers, from breaches in isolation precautions, and from contact with contaminated equipment, or other surfaces. It is not airborne. VRE can cause a variety of infections, most commonly surgical site and urinary tract infections. Patients who have VRE are cared for in strict isolation—in a single room with dedicated equipment that is not used for other patients. Careful hand hygiene before and after contact with the infected patient or their environment is the most important control measure in preventing transmission. The surveillance for these incidence rates includes the HI, VG, 9 Abbie Lane, VMB 3 East, and the Rehabilitation Centre, with the exception of 2010 & 2011 which also includes the Dartmouth General and Hants Community Hospitals (Haliburton Place excluded).	
Analysis and Progress: A summary of quarterly VRE incidence rates can be seen in the graph below. According to the Canadian Nosocomial Infection Surveillance Program of the Public Health Agency of Canada, the most recent national rate was 6.4 per 1000 patient days (2009). The rates have been far below the 2009 national rate, but an increase is emerging in Q3 2011/12.	

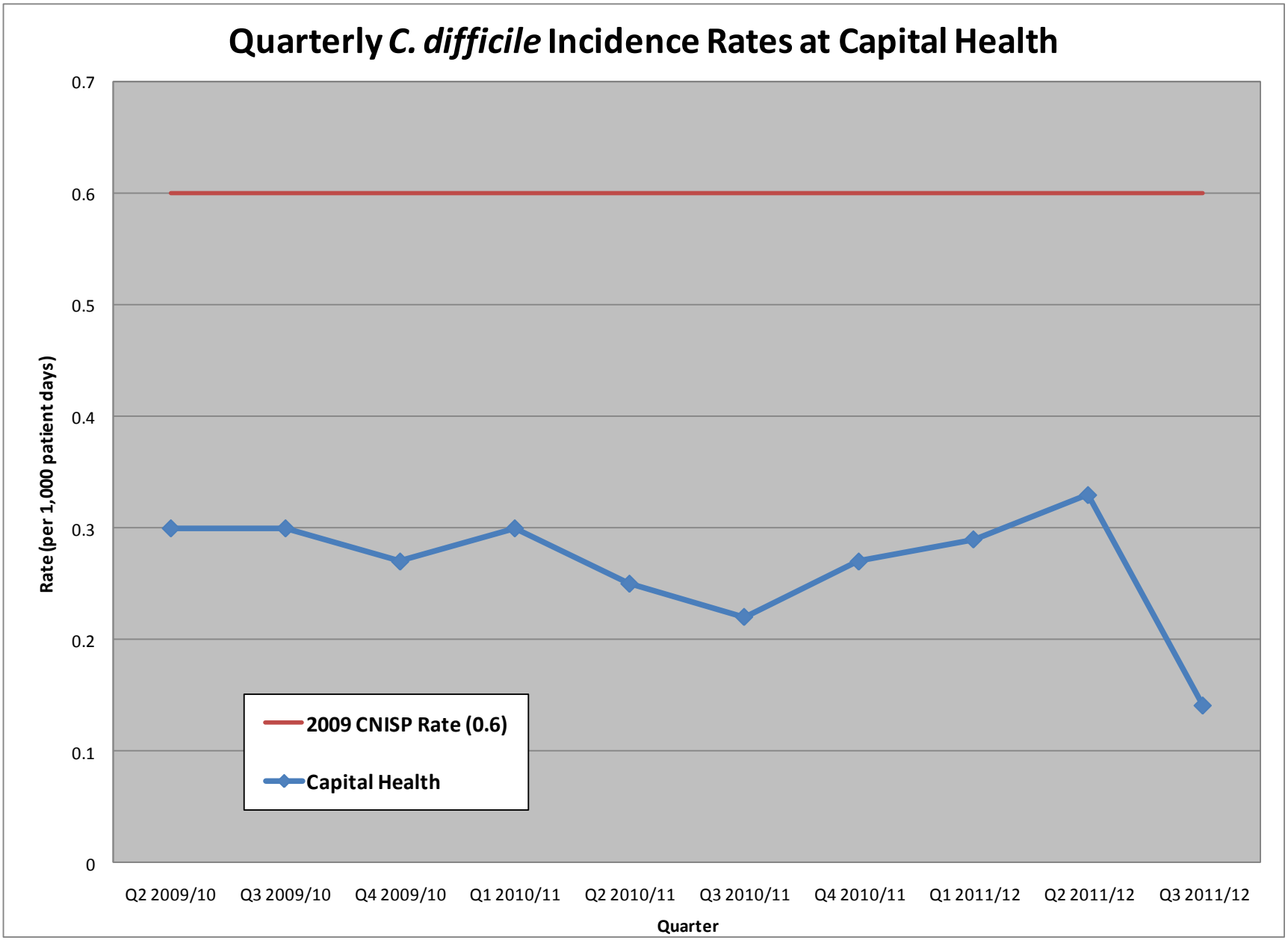
Source: Infection Control	Frequency Tracked: Quarterly	Last Updated: June 2012
Accountability: Catherine Gaulton, Mary Ellen Gurnham, Lynn Johnston		Next Update Expected: September 2012

Note: as of the June 2012 version of this report, the rates have been changed from per 1,000 *admissions* to per 1,000 *patient days*.



3.1.18 Infection Rate - C. difficile	**Patient Safety Indicator**	
Strategic Stream: Person-Centered Health Care		
Status: ☑ Meeting target	Trend: Decreasing	
Formula: Total cases of *C. difficile* divided by the total patient days, multiplied by 1,000 , to get a rate per 1,000 patient days. **Note: as of the June 2012 version of this report, the rates have been changed from per 1,000 *admissions* to per 1,000 *patient days*.**		
Description: *Clostridium difficile* or *C. difficile* is a bacterium that causes diarrhea and more serious intestinal conditions such as colitis. It is the most common cause of infectious diarrhea in hospitalized patients in the industrialized world. It is also one of the most common infections in hospitals and long-term care facilities (reference: Public Health Agency of Canada (PHAC)). The use of antibiotics increases the chances of developing *C. difficile* diarrhea. Treatment with antibiotics alters the normal levels of good bacteria found in the intestines and colon. When there are fewer of these good bacteria, *C. difficile* can thrive and produce toxins that can cause an infection. The combination of the presence of *C. difficile* in hospitals and other health care settings, and the number of people receiving antibiotics in these venues can lead to frequent outbreaks (reference: PHAC). In these situations, *C. difficile* infections can be limited through careful use of antibiotics and the use of routine infection control measures. The PHAC has developed infection control guidelines for use by the provinces, territories, and health care organizations. The surveillance for these infection rates includes the HI, VG, 9 Abbie Lane, VMB 3 East, and the Rehabilitation Centre, with the exception of 2010 & 2011 which also includes the Dartmouth General and Hants Community Hospitals (Haliburton Place excluded).		
Analysis and Progress: The *C. difficile* hospital infection rates are shown in the graph below. The most recent national rate reported by the Canadian Nosocomial Infection Surveillance Program of the PHAC was 0.6 per 1,000 patient days (2009). The rate at Capital Health has remained well below the national rate.		
Source: Infection Control	Frequency Tracked: Quarterly	Last Updated: June 2012
Accountability: Catherine Gaulton, Mary Ellen Gurnham, Lynn Johnston		Next Update Expected: September 2012

Note: as of the June 2012 version of this report, the rates have been changed from per 1,000 *admissions* to per 1,000 *patient days*.

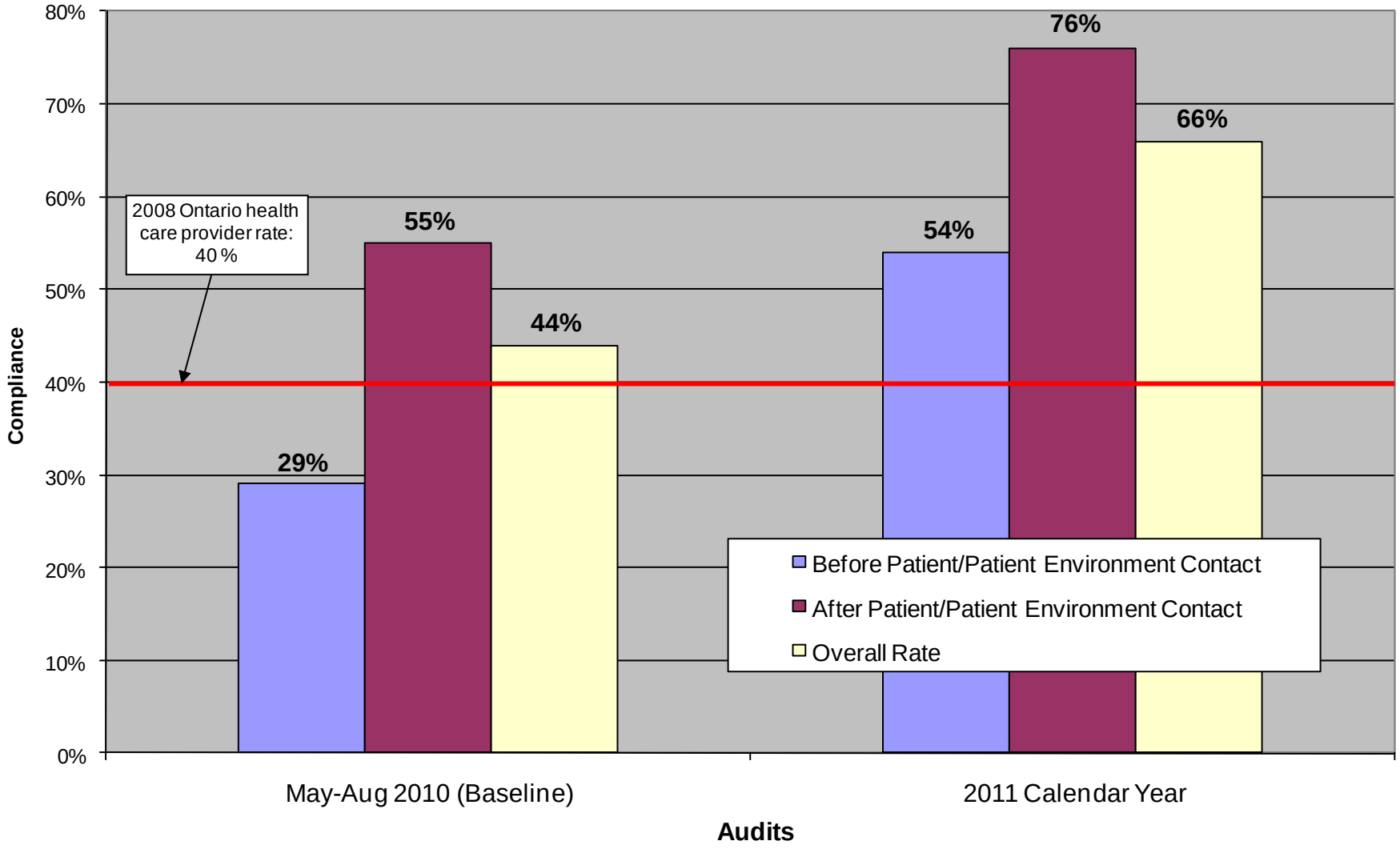


3.1.19 Hand Hygiene Compliance	**Patient Safety Indicator**
Strategic Stream: Person-Centered Health Care	
Status: ☑ Meeting target	Trend: 2011 has shown great improvement over 2010
Formula: The number of times hand hygiene was performed divided by the number of times hand hygiene was required, multiplied by 100.	
Description: As caregivers move from patient to patient and room to room caring for people, their hands pick up microorganisms which can cause infections. Hand hygiene works by interrupting this transmission of microorganisms. Promoting hand hygiene is considered the cornerstone of infection prevention and control programs and of preventing healthcare-associated infections. The World Health Organization has suggested improvements in hand hygiene compliance can prevent 50% of hospital-associated infections, making it the single most important practice in reducing the rate of such infections. Measuring adherence and providing feedback with accepted hand hygiene practices is an important quality improvement tool. The Accreditation Canada Qmentum Program now includes hand hygiene audits as one of the required organizational practices within the Infection Prevention and Control Standards. As a part of Accreditation, Capital Health is required to audit compliance with hand hygiene practices, share these results, and use the results to make improvements to current practices. The audit (and compliance) is based on the Four Moments for Hand Hygiene, the times at which hand hygiene should occur: 1. Before initial patient/patient environment contact 2. Before aseptic procedure 3. After body fluid exposure risk 4. After patient/ patient environment contact. Literature from 2008 indicates compliance with hand hygiene for Ontario health care providers was less than 40 %.[2]	
Analysis and Progress: The graph below shows the percentage compliance with hand hygiene at Capital Health, broken down by before and after patient/patient environment contact. In 2010 the overall rate of compliance was 44 % (baseline). In 2011 the overall rate was 66 %, a great improvement over the rate in 2010. Both years are shown to have better (higher) rates than the overall Ontario health care provider rate of less than 40 % mentioned above.	

Source: Infection Control	Frequency Tracked: Twice a year	Last Updated: January 2012
Accountability: Catherine Gaulton, Mary Ellen Gurnham, Lynn Johnston		Next Update Expected: Summer 2012

[2] McGeer, A., Hand hygiene by habit. *Ontario Medical Review*, 2008; 75 (3)

Hand Hygiene Compliance at Capital Health
2010 and 2011



3.1.20 Emergency Department - Percentage of Patients Left Without Being Seen

Strategic Stream: Person-Centered Health Care

Status: ☒ Not meeting target	Trend: See the graph

Formula: Number of patients who left the emergency department without being seen by a physician divided by the total number of emergency registrations.

Description: Each month, hundreds of patients who arrive at emergency departments across Capital Health subsequently leave without being seen by a physician. While many of these patients may have symptoms or conditions that can safely be dealt with by alternative means, it is a concern that someone with a significant problem may leave and the consequences could be serious. At the Dartmouth General, a discharge planning nurse keeps a record of patients who leave without being seen and calls patients to provide follow up suggestions. The count of patients who left without being seen does not include those patients who were seen by a nurse in the emergency department instead of being seen by a physician.

The target is to keep walkouts below 2% all across Capital Health.

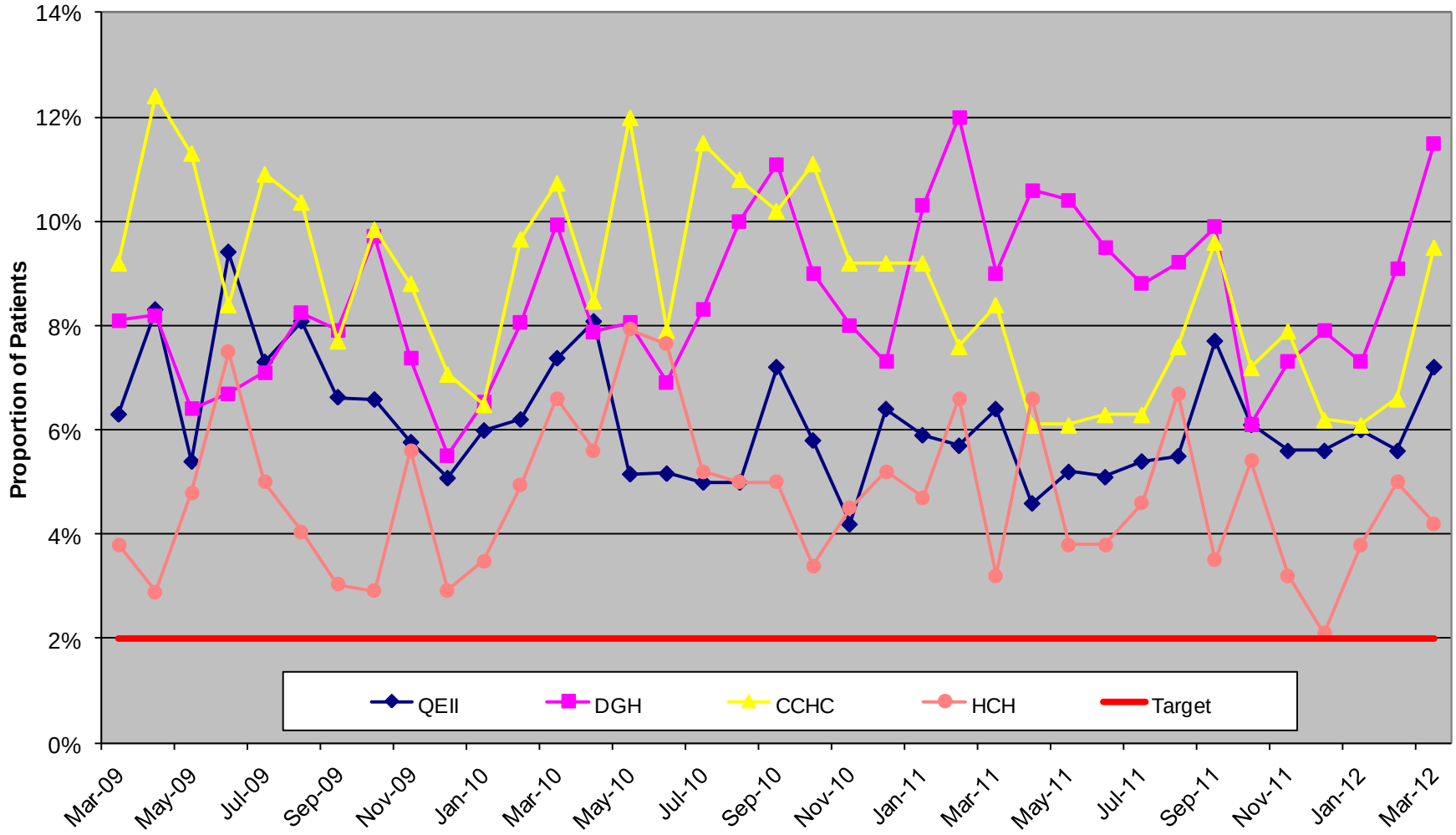
Analysis and Progress: The graph below shows the percent of patients who left the emergency department without being seen (all triage acuity levels combined). A breakdown by emergency department site is shown. All sites are over the target of 2%.

A failure modes and effects analysis process is being applied to the issue of patients leaving without being seen to see if there are root causes, and to determine the factors that influence patients' decisions to leave which will help focus on the development of solutions.

In January, two initiatives have started that will increase capacity within the Dartmouth General ED: 1) expanded hours on the minor side. This was previously only staffed until 7:00 pm and now it is staffed until 11:00 pm; and 2) trial period of a chair zone which will be staffed by an LPN- this will care for Level 4's & 5's or stable level 3's. This will be staffed from 11:00 am to 7:00 pm.

Source: EDIS	Frequency Tracked: Monthly	Last Updated: May 2012
Accountability: Barbara Hall, Sandra Janes, David Petrie, Samuel Campbell		Next Update Expected: July 2012

Percentage of Emergency Patients Leaving Without Having Been Seen by a Physician
March 2009 to March 2012



3.1.21 Long Term Care - Patients Placed and Waiting to be Placed

Strategic Stream: Person-Centered Health Care

Status: ☒ Not meeting target	Trend: See graphs

Formula: Number of patients placed and number of patients awaiting placement in long term care (LTC) facilities. Includes patients at all Capital Health sites.

Description: These graphs represent LTC patients from all Capital Health facilities—both acute care and mental health LTC patients are included. At any one time, patients who require care—but not acute care—may occupy a substantial number of beds in hospital facilities. Often they cannot be discharged from hospital until alternate services, such as residential care, are available. For this reason, a measure of the number of patients waiting to be placed is a measure of appropriate hospital utilization and the ability to respond to client needs.

Once a patient's application is approved, they remain on a waitlist until a bed in the appropriate type of facility becomes available, unless their medical status changes. The application process involves a standardized provincial application, consisting of both health and financial assessments.

Analysis and Progress: The graphs below show the number of Capital Health patients *placed* and *waiting to be placed* into LTC facilities. In April 2012, the total number of patients at all Capital Health facilities who were waiting to be placed in LTC facilities was 142. This number has remained relatively stable but well **above the target of 75**. The high number of placements shown in April 2010 at the QEII is related to the April opening of the new LTC facility, Northwood West Bedford Continuing Care Centre, when 59 patients from the QEII were placed there.

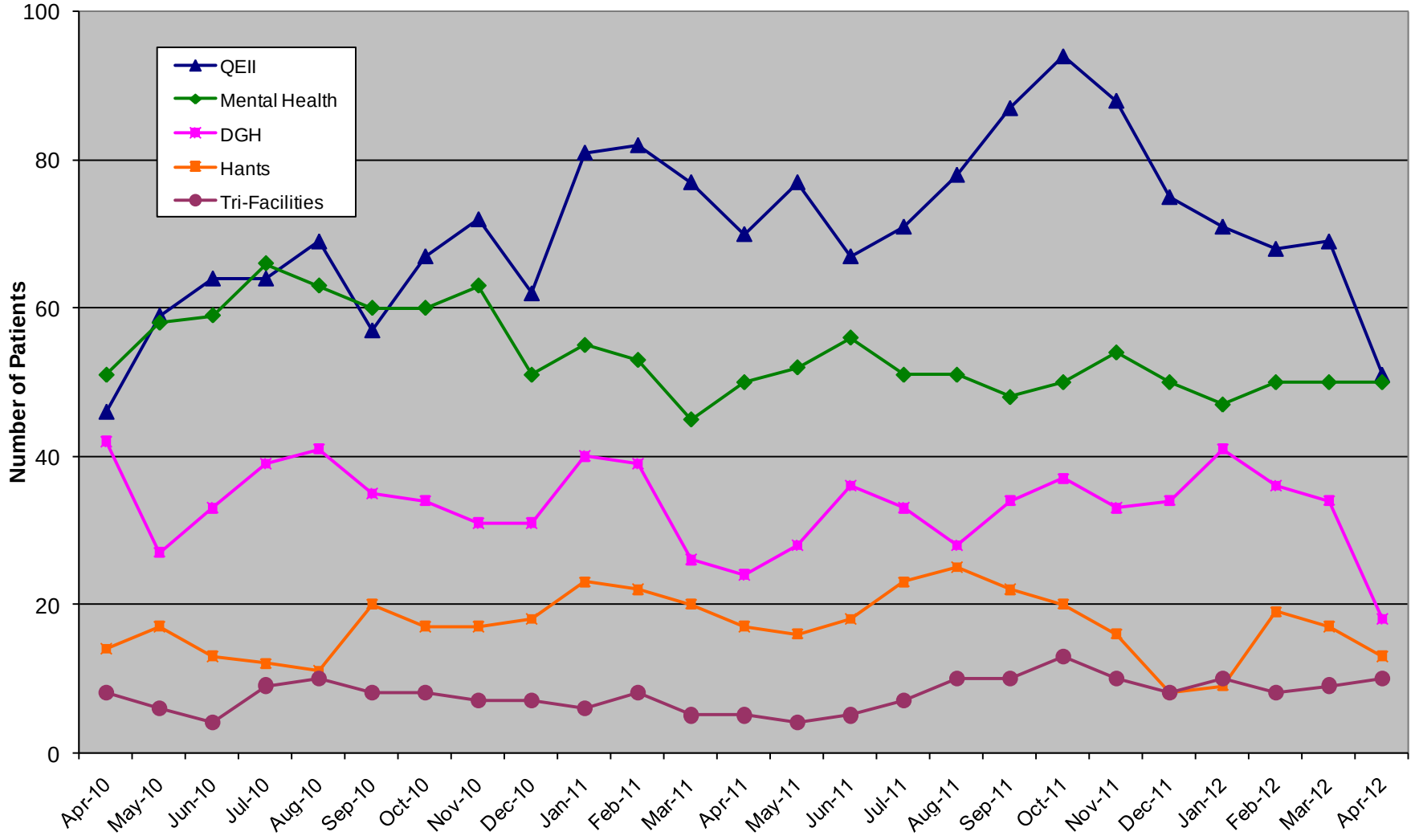
In order to meet the LTC needs of their patient population, the Mental Health Program works with the Department of Health and Wellness (DoHW) for traditional LTC (nursing home) placements, as well as with the Department of Community Services (DCS) for non-traditional LTC placements such as Adult Residential and Small Options. DCS operates under a different set of rules & guidelines than DoHW and in a more risk averse and cautious manner. This results in Mental Health experiencing a much higher percentage of beds being occupied by patients awaiting placement, by comparison.

Lengths of stay are only a snapshot of what is documented in the LTC/ALC database at the time of publication of this report. April 2012 data were extracted on May 16th, 2012.

In Capital Health, as of June 6th, 2012, there were 718 people in the community waiting to be placed in LTC facilities. The number of people waiting in the community during the same time last year (June 8th, 2011) was 449 (source: Department of Health and Wellness SEAscape database).

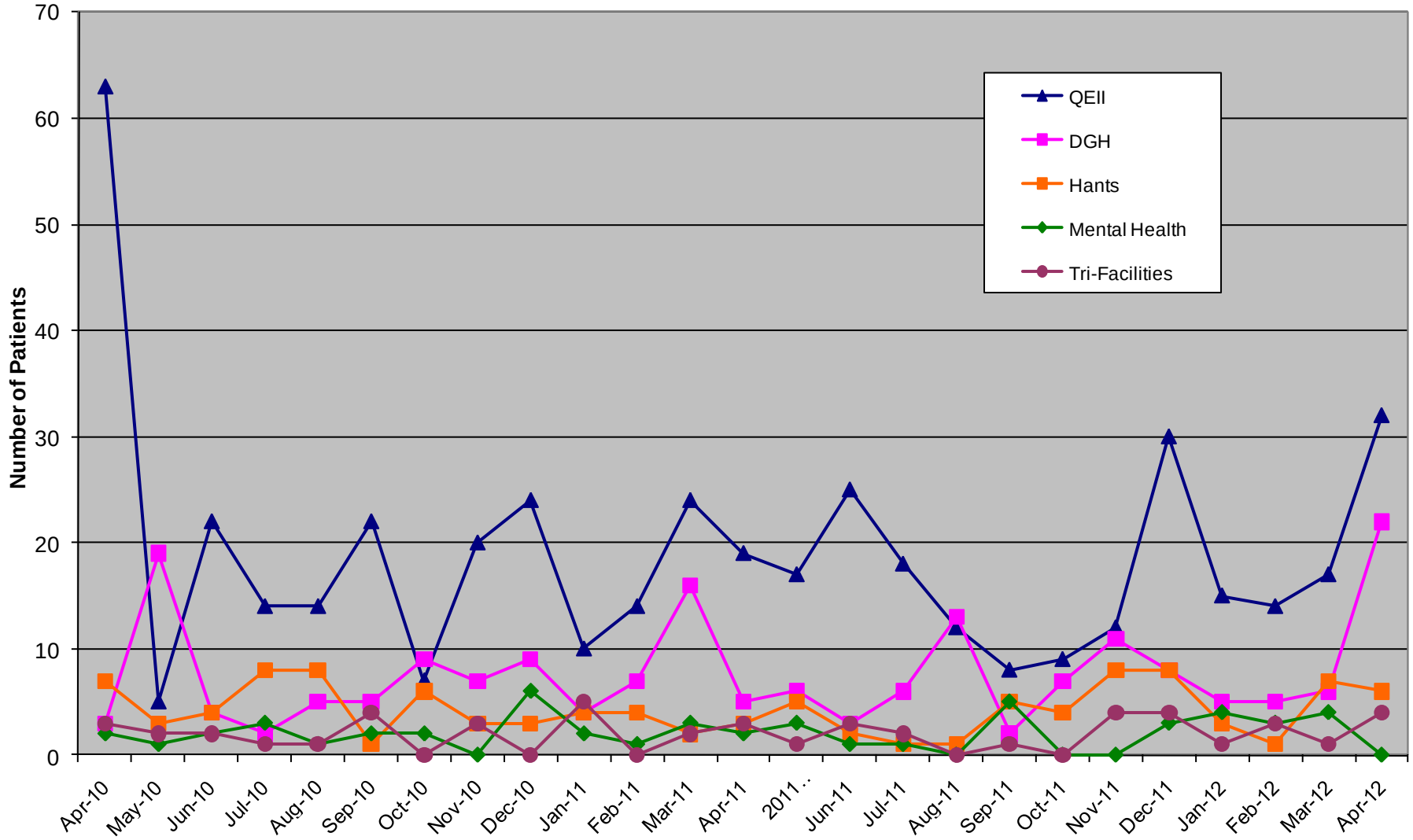
Data Source: Site Coordinators	Frequency Tracked: Monthly	Last Updated: June 2012
Accountability: Barbara Hall		Next Update Expected: July 2012

Capital Health Patients *Waiting to be Placed* in LTC
April 2010 to April 2012



Capital Health Patients *Placed* in LTC

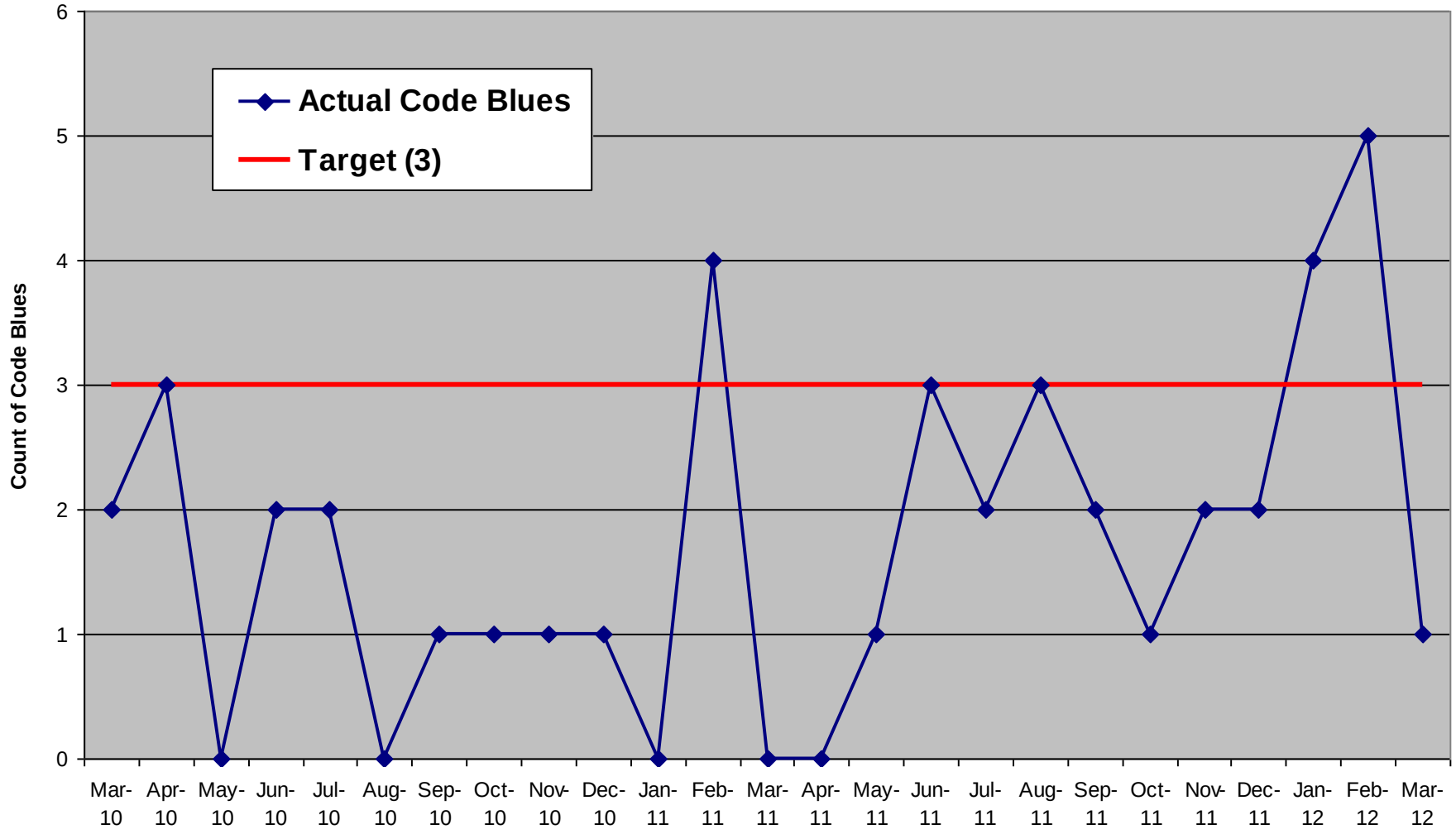
April 2010 to April 2012



3.1.22.1 Code Blue Count (Impact of Quick Response Team)	**Patient Safety Indicator**	
Strategic Stream: Person-Centered Health Care		
Status: ☑ Meeting target	Trend: staying at or below target	
Formula: The count of inpatient code blues per month at the Dartmouth General Hospital (DGH)		
Description: The Quick Response Team (QRT) (sometimes referred to as a rapid response team or a medical emergency team in other institutions) is a medical team designed to prevent patients from deteriorating to the point of requiring a code blue. A code blue is defined as the need for a response to a known or suspected cardio-respiratory arrest. A QRT was implemented at the DGH unit by unit in late 2005 until full implementation was reached in January 2006. The QRT at DGH is comprised of a physician, an ICU nurse, and a respiratory therapist. The QRT is called upon when a staff member is worried about a patient or when a patient meets specified clinical criteria indicating physiological instability that may lead to an arrest. When called, the team assists the staff member caring for the patient in assessing and stabilizing the patient's condition. The QRT members also take on the role of educator and support to the staff. If the circumstances warrant, the QRT may recommend the transfer of the patient to a higher level of care and may help facilitate this transfer. In 2005, the average number of code blues per month was 5.62. The goal was to decrease the number of code blues by 50% or to three or fewer per month.		
Analysis and Progress: The graph below shows the monthly counts of code blues at the DGH. It can be seen that the target of three or fewer codes was met for 2010/11 (except for in February 2011). In 2011/12, the target has also been met, with the exception of January and February. The DGH has been designated as a mentor in the Safer Healthcare Now! mentor network for facilities implementing similar response teams. Discussions are underway to implement a response team at the QEII.		
Source: Performance Excellence	Frequency Tracked: Quarterly	Last Updated: May 2012
Accountability: QRT Code Committee, Heather Francis, Matt Watson		Next Update Expected: August 2012

Count of Code Blues at the Dartmouth General

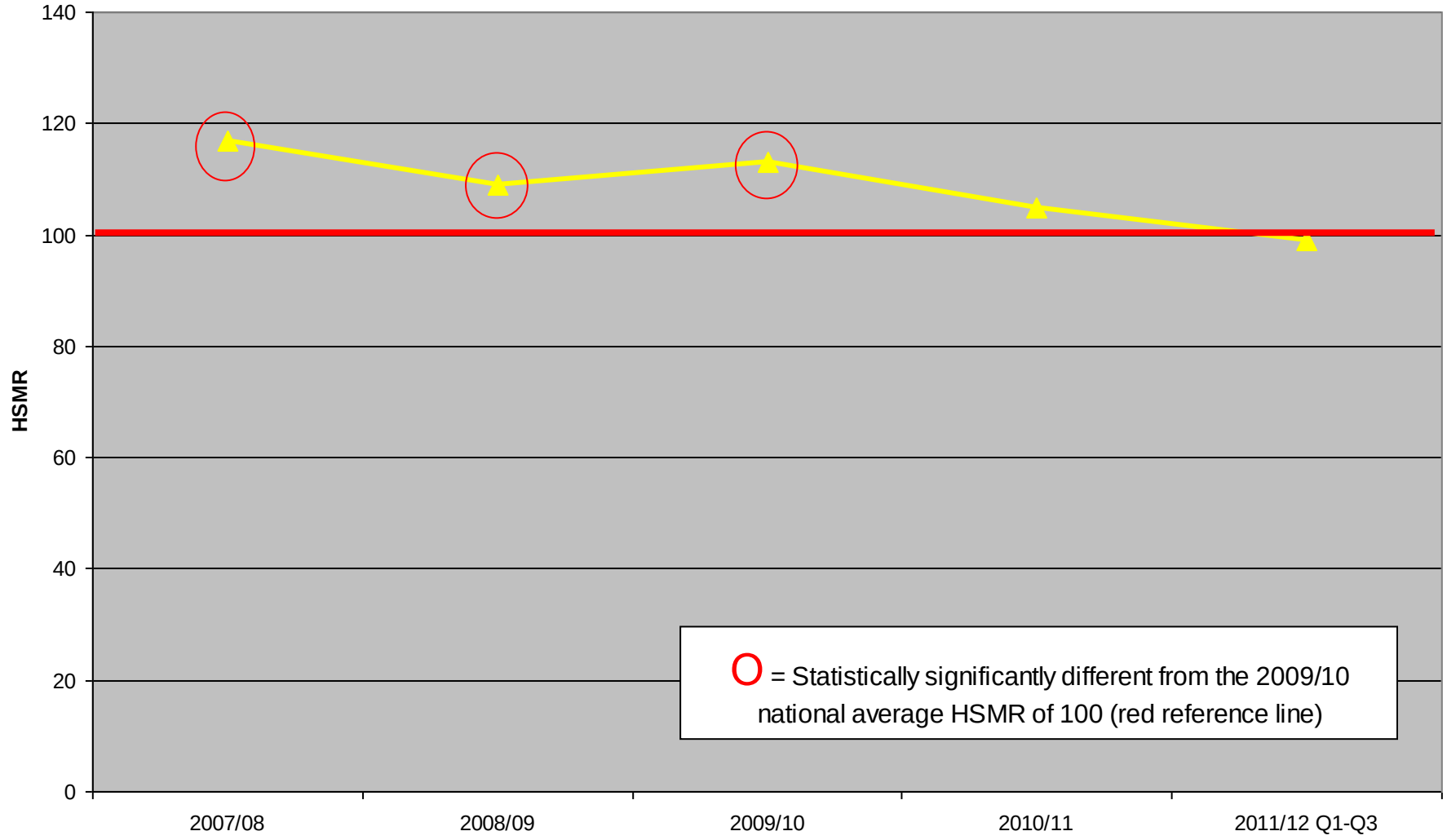
March 2010 to March 2012



3.1.23 Hospital Standardized Mortality Ratio	**Patient Safety Indicator**	
Strategic Stream: Person-Centered Health Care		
Status: ☑ Meeting target (using the 2009/10 national average)	Trend: on par with the 2009/10 national average	
Formula: Hospital standardized mortality ratio (HSMR) is the ratio of actual deaths to expected deaths, multiplied by 100. This indicator is calculated by the Canadian Institute for Health Information (CIHI). It is adjusted based on several factors.		
Description: HSMR is a key indicator that can help support efforts to improve patient safety and quality of care. The HSMR compares the actual number of deaths in a hospital with the average Canadian experience, after adjusting for several factors that may affect in-hospital mortality rates, such as differences in age, sex, length of stay, admission category (planned vs. urgent/emergent), diagnosis group, selected comorbidities, and transfer from another acute care institution. CIHI calculates the ratios using data submitted from hospitals across the country. It only includes the 72 diagnosis groups that account for the top 80% of in-hospital deaths in Canada. The ratio provides a starting point to assess mortality rates and identify areas for improvement, which may help to reduce hospital deaths from adverse events. Fiscal year 2009/10 is the baseline year in which the national average has been designated as 100. As such, an HSMR greater than 100 suggests the local mortality rate is higher than the national experience in 2009/10 (unfavourable). Conversely, HSMR scores les than 100 suggest the local mortality rate is lower than the national experience in 2009/10 (favourable). The baseline year used to be 2004/05 but in 2012, CIHI recalculated HSMR scores to use the 2009/10 national average as the baseline. With hospitals across the country improving their mortality rates over the past several years, the upward shift of the new HSMR scores is not a surprise since the new national average baseline "raised the bar" for hospitals across the country.		
Analysis and Progress: The graph below shows the HSMR for CDHA for fiscal years 2007/08 to 2011/12. In fiscal years 2007/08 to 2009/10, CDHA had HSMRs that were statistically significantly worse than the 2009/10 national average (i.e. greater than 100), but had HSMRs that were on par with the 2009/10 national average (i.e. less than 100) for fiscal years 2010/11 and 2011/12.		
Source: CIHI, Decision Support	Frequency Tracked: Quarterly	Last Updated: May 2012
Accountability:		Next Update Expected: Fall 2012

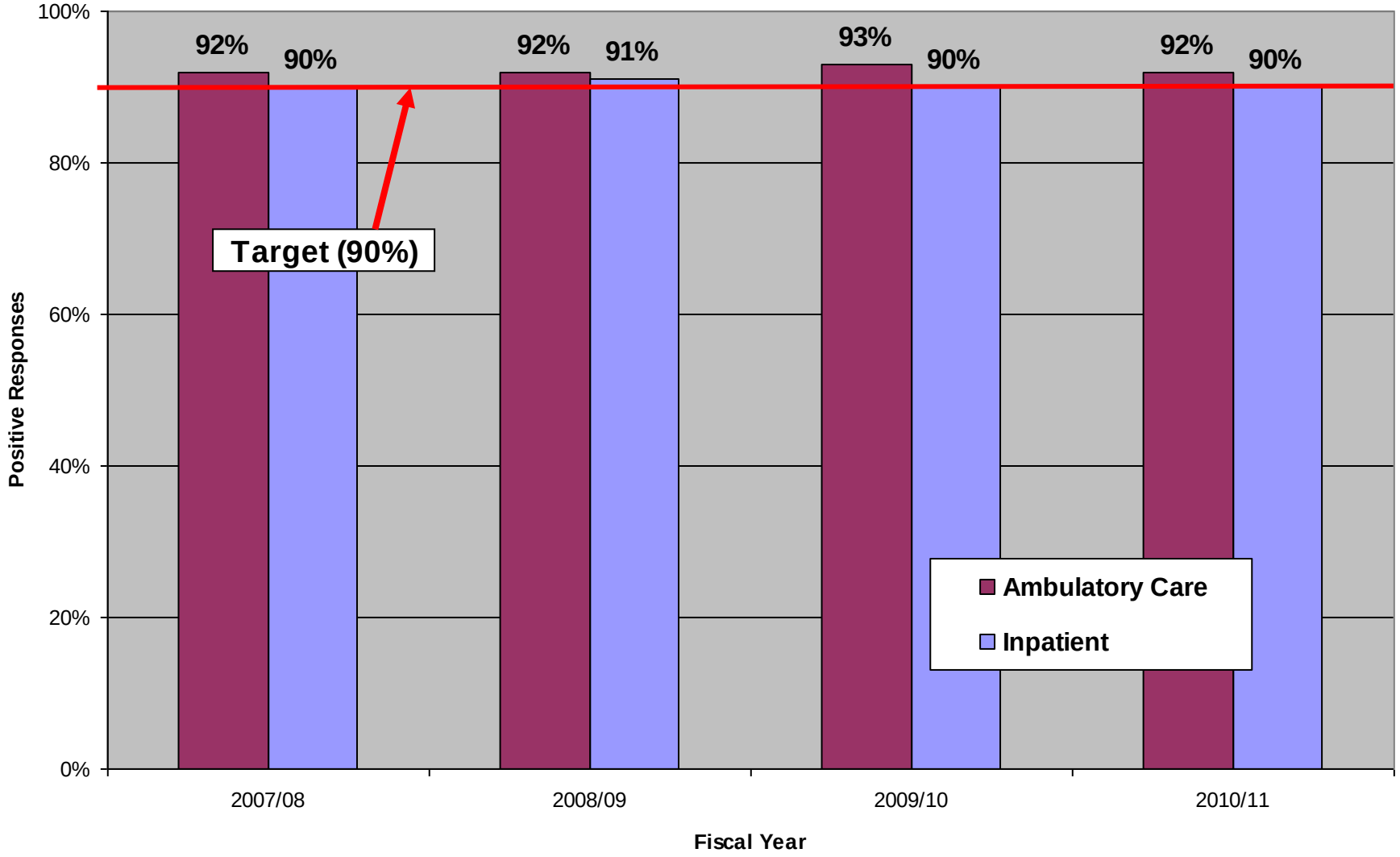
Hospital Standardized Mortality Ratio at CDHA

Fiscal Years 2007/08 to 2011/12



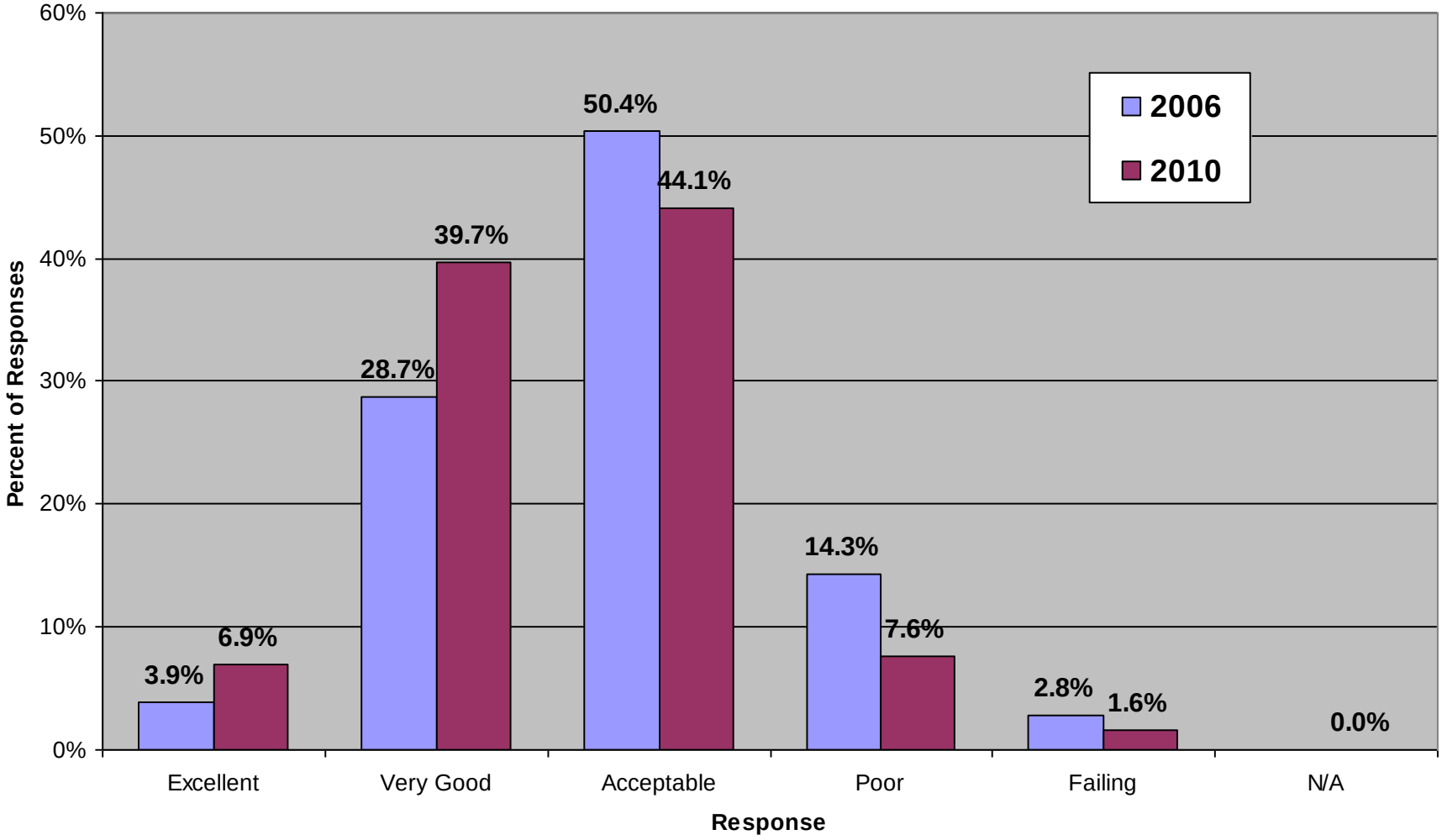
3.1.24 Patient Satisfaction		
Strategic Stream: Person-Centered Health Care		
Status: ☑ Meeting target	Trend: Meeting target since the 2007/08 survey.	
Formula: Number of positive responses divided by the total number of responses, multiplied by 100 (all survey questions and all respondents combined). Positive responses may include more than one of the possible responses, such as "very satisfied", and "satisfied."		
Description: As a commitment to quality improvement for patients and their families, CDHA requires feedback on an ongoing basis. Throughout the year, patients in inpatient, ambulatory and rehabilitation services are randomly sampled to partake in the patient satisfaction survey and the results are reported annually. The survey results can be used to identify strengths and opportunities for quality improvement initiatives and accreditation requirements. The satisfaction target has been set at 90%. The data presented here are an overall summary of the responses to all questions on the Inpatient Patient Satisfaction Survey and the Outpatient/Ambulatory Patient Satisfaction Survey. Mental Health and Emergency Department patients are not included; they are surveyed separately using a different tool.		
Analysis and Progress: The graph below shows the percentage of positive responses for the CDHA Patient Satisfaction Survey for 2007/08 to 2010/11 with a breakdown of responses for inpatient and ambulatory care survey respondents. For both inpatient and ambulatory care patients the percent of positive responses remains favorable—at or above the target of 90%.		
Source: CDHA Patient Satisfaction Survey	Frequency Tracked: Yearly	Last Updated: July 2011
Accountability: Catherine Gaulton		Next Update Expected: Summer 2012

Percentage of Positive Responses in the CDHA Patient Satisfaction Survey for 2007/08 to 2010/11



3.1.25 Patient Safety Culture		**Patient Safety Indicator**
Strategic Stream: Person-Centered Health Care		
Status: No target		Trend: 2010 shows improvement over 2006
Formula: Percent of responses to each possible answer for the Patient Safety Culture survey question related to overall grade on patient safety.		
Description: The CDHA Patient Safety Culture Survey was first completed in 2006 (2082 respondents) and was conducted again in 2010 (3290 respondents). It consisted of 40+ questions about the culture around patient safety at Capital Health. Respondents were asked to choose one of six possible answers for each question. The survey question of interest here is "Please give the organization an overall grade on patient safety" with the following possible answers: Excellent, Very Good, Acceptable, Poor, Failing, and N/A. Note that the 2006 survey did not provide the "N/A" option.		
Analysis and Progress: The graph below shows the percentage of responses for each of the possible answers for the question related to overall grade on patient safety. In both 2006 and 2010, the majority of the responses fell under the "Very Good" and "Acceptable" response categories. In 2010, there was a decrease in the percent of "Acceptable", "Poor", and "Failing" responses and an increase in the "Excellent" and "Very Good" responses as compared to 2006.		
Source: Patient Safety Culture Report (2006, 2010)	Frequency Tracked: Every 3 years	Last Updated: September 2010
Accountability: Catherine Gaulton		Next Update Expected: 2013

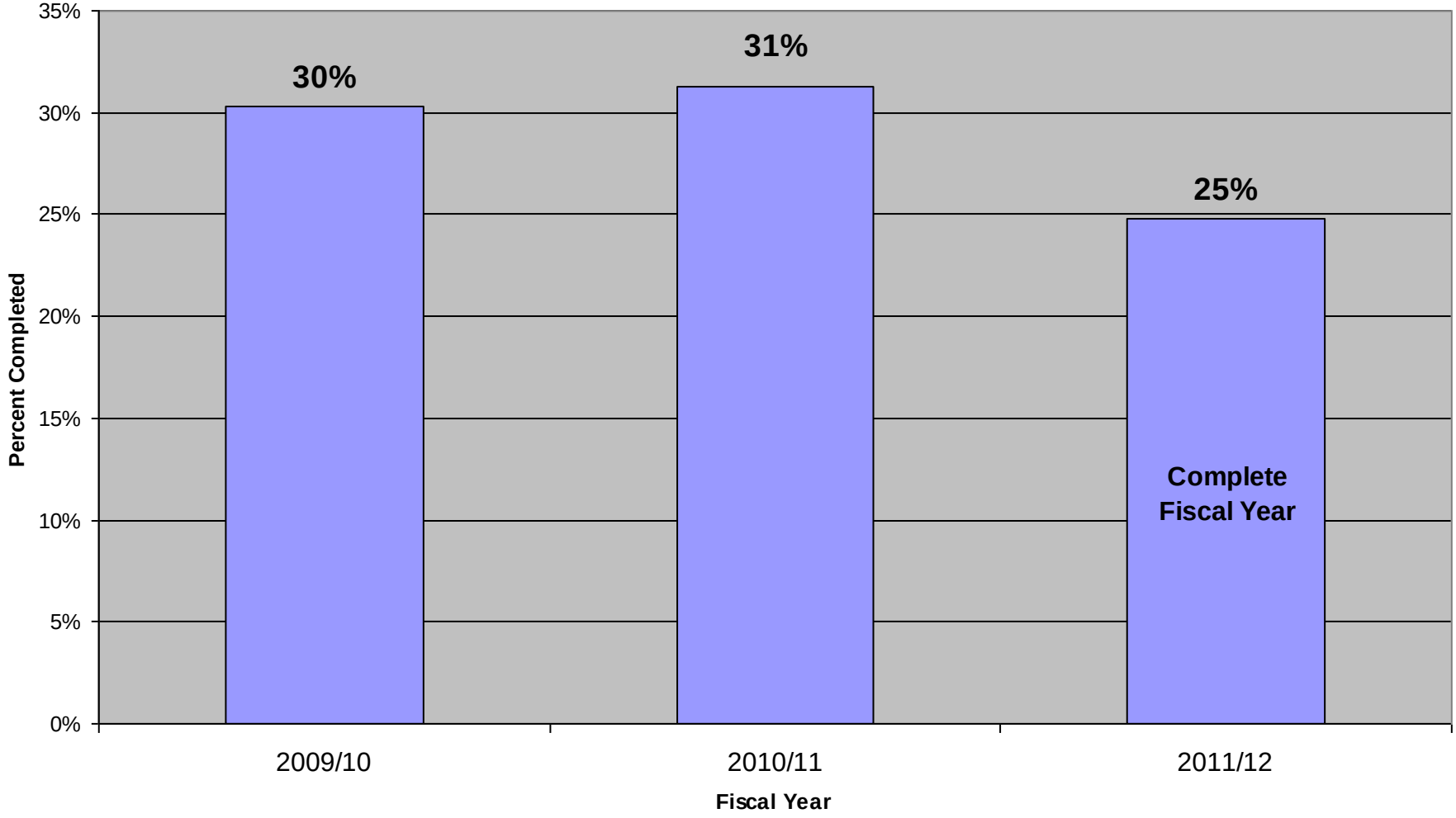
Overall Grade on Patient Safety from the 2006 & 2010 Capital Health Patient Safety Culture Surveys



3.1.26 Completion of Patient Safety Training	**Patient Safety Indicator**	
Strategic Stream: Person-Centered Health Care		
Status: ☒ Not meeting target	Trend: 2011/12 had a lower completion rate than each of the past two years.	
Formula: The number of employees who completed *at least one* patient safety course, divided by the total number of Capital Health employees, multiplied by 100.		
Description: A required organizational practice (ROP) is an essential practice organizations must have in place to enhance patient/client safety and minimize risk. One of Accreditation Canada's ROPs is the delivery of client safety training and education at least annually to employees. To fulfill this ROP, CDHA requires all employees and volunteers to annually complete at least one patient safety course. Most employees can fulfill this requirement by completing one of the six online patient safety courses using the Learning Management System (LMS). Others, such as volunteers, are provided the training as part of orientation packages and presentations. The following employee types are included in the denominator for this rate calculation: confidential exclusion, executive, management, NS labour standard, NSGEU healthcare, NSGEU nursing, NSGEU office & clerical, NSGEU support services, NSNU nursing, residents (PARI-MP), physicians, research, clinical clerks, volunteers, and academic learners. Employees on leave are excluded. It should be noted that clinical clerks, volunteers, and academic learners do not have access to the LMS. The employee count for 2009/10 was as of March 31, 2010. The count for the first three quarters of 2010/11 was as of November 15, 2010. Completion of courses through LMS is tracked, but delivery of presentations and orientation packages to individuals is not. Such packages are delivered to CDHA volunteers on a consistent basis, so an estimate of an 80% completion rate has been used for volunteers.		
Analysis and Progress: The graph below shows the percentage of CDHA employees, medical staff, learners, and volunteers who completed at least one patient safety course in recent fiscal years. In 2009/10, 30% of employees completed a patient safety course, and in 2010/11 the figure was 31%. For 2011/12, the rate was 25%.		
Sources: LMS, People Services, Medical Services Information System, CDHA Annual Report	Frequency Tracked: Quarterly	Last Updated: May 2012
Accountability: Catherine Gaulton		Next Update Expected: August 2012

Percentage of CDHA Employees, Medical Staff, Learners, and Volunteers Having Completed at Least One Patient Safety Training Course

2009/10 to 2011/12



3.2 Sustainability

This section contains a number of indicators focused on measuring health of the population (population health indicators), stewardship role of public resources and impact on the environment, and safety of physical spaces and equipment.

3.2.1 Access to a Primary Health Care Team		
Strategic Stream: Sustainability		
Status: ☑ Met the 2011/12 target (as the target was established at a level below the system baseline)	Trend: n/a	
Formula: % of family physicians that are practicing as part of an interdisciplinary team (working with a Family Practice Nurse (FPN), or a Nurse Practitioner (NP) only).		
Description: To help ensure patients have access to the appropriate resource within their community health setting. The *Our Promise Milestones* are to support accessibility to primary health care interdisciplinary teams by 10% in 2010/11, 15% by 2011/12, and 25% by 2012/13. Interdisciplinary Primary Health Care Teams are defined as including a nurse or other health professional (e.g. dietician or nutritionist) or both at their medical doctor's office or health clinic.		
Analysis and Progress: Primary Health Care continues to support the family practice nurse initiative. Funding did not support the plan to expand the number of teams in 2010/11. As of March 2011, there were approximately 20% of family physicians (in full service practices) that practice within an interdisciplinary team (based on having a Family Practice Nurse (FPN), or a Nurse Practitioner (NP) only). (345 family physicians included as full service practices with 69 of them associated with a FPN or NP.) This measure will change if there is funding or shifting resources to support a team approach in primary health care and this has not been the case at this time.		
Source: Primary Health Care	Frequency Tracked:	Last Updated: March 2012
Accountability: Barbara Hall		Next Update Expected: 2013

3.2.2 Increased Investment in Primary Care & Care of the Elderly		
Strategic Stream: Sustainability		
Status: ☑ Has met the 2011/12 target	Trend:	
Formula: n/a		
Description: Capital Health needs to invest in community supports and resources to better meet patient needs and gain service efficiencies. The 2013 Milestone Target is to have a 1% increase in investment per year. The baseline is the 2009/10 budget for Capital Health services: Primary Care, Continuing Care, and Outpatient Geriatric services which totaled: $28,091,680. The 2010/11 target is a 1% increase which equals an increase of $280,916. The 2011/12 target is a 1% increase over 2010/11 which translates into an increase of $561,834.		
Analysis and Progress: Through the 2010/11 business planning process $440,000 was committed for fiscal 2010/11 to support the Community Master Plan implementation. Targeted investment money in the amount of $690,000 has been authorized for the 2011/12 fiscal year, thus the 2011/12 target has been met.		
Source: Barbara Hall	Frequency Tracked: Yearly (with each budget)	Last Updated: November 2011
Accountability: Barbara Hall		Next Update Expected: Winter 2012

3.2.3 Percent of Alternate Level of Care Beds Vacated and Closed Permanently

Strategic Stream: Sustainability

Status: ☒ Did not meet the 2011/12 target

Trend: 40 % of ALC beds vacated & closed.

Formula: Number of transitional care or alternate level of care (ALC) beds at Capital Health vacated and closed permanently, divided by the total number of ALC beds available at the end of 2009/10.

Description: To help ensure patients with ALC needs are cared for in facilities that are specifically designed to meet the needs of this population, the Our Promise Milestones are to vacate and close permanently 40% of ALC beds by 2010/11, 60% by 2011/12, and 75% by 2012/13. Also, part of the goal is to reinvest the resources freed up as a result of the bed closures. This goal does not include mental health. The baseline year is 2009/10.

Analysis and Progress: The baseline against which percent closure is measured is the total transitional care beds at all Capital Health facilities at the end of 2009/10 (see table below), which was 110. In 2010/11, the target of closing 40% of beds was not met. As of April 5th, 2012, there were 69 transitional care beds. This is a decrease of 41 beds or 37% since 2009/10 – so the target of a 60% decrease was not met for 2011/12. As of June 11th, 2012, there was a decrease of 38% of beds from the 2009/10 baseline.

Facility	Bed Counts	
	2009/10 (Baseline)	June 11, 2012
QEII	59	16
Dartmouth General	31	33
Hants Community	12	12
Twin Oaks Memorial	5	5
Musquodoboit Valley Memorial	1	1
Eastern Shore Memorial	2	1
TOTAL	**110**	**68**
Percentage Decrease from Baseline	**n/a**	**38%**

Resources have been freed up and some have been applied to creating the virtual bed program in the community. The business plan for DGH proposes some of the transitional care beds be converted to acute care beds to increase much needed acute care capacity. In order to do so, more community capacity must be created. Several provincial initiatives are underway to improve access to community options over the coming year.

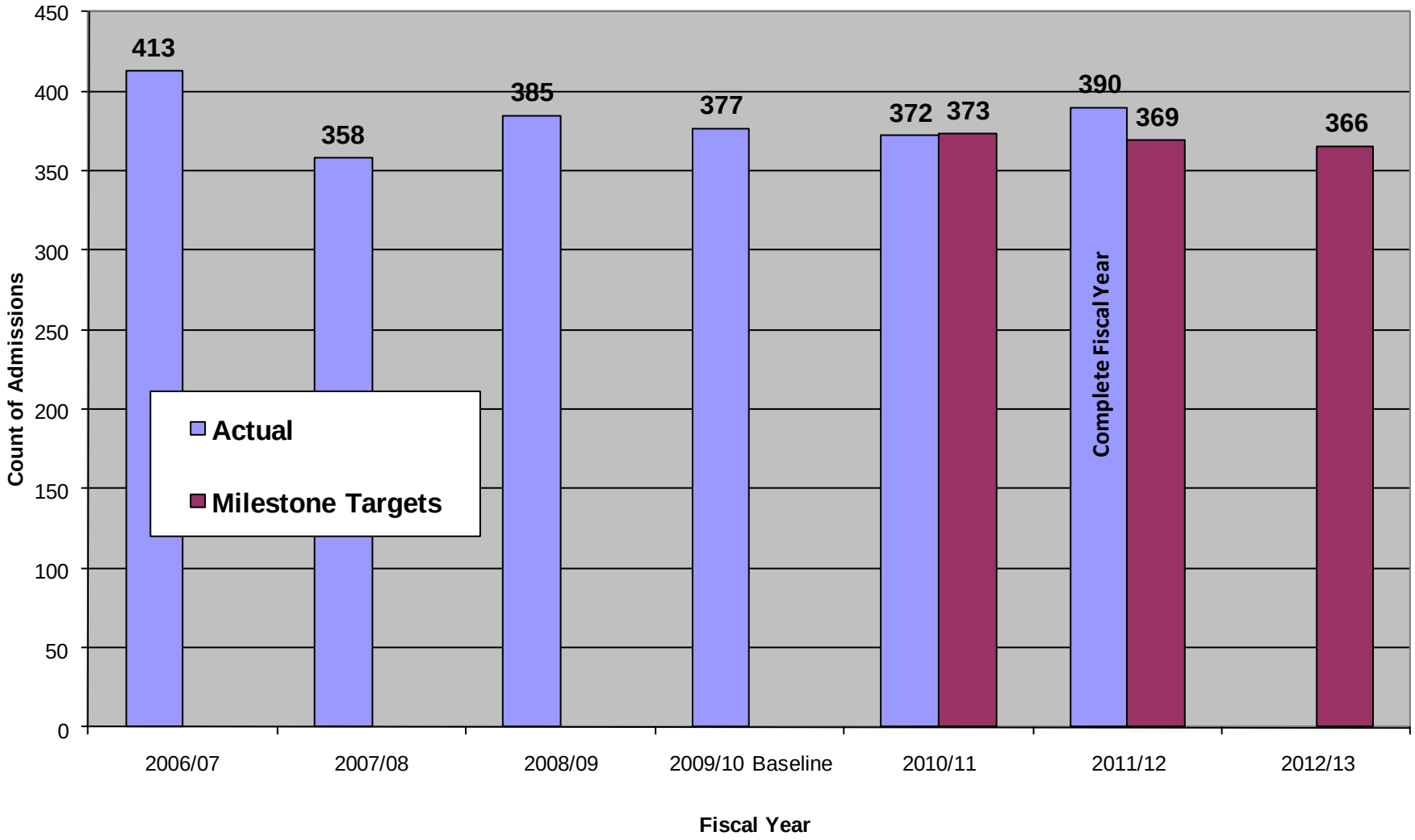
Source: STAR | Frequency Tracked: Monthly | Last Updated: June 2012

Accountability: Barbara Hall | Next Update Expected: July 2012

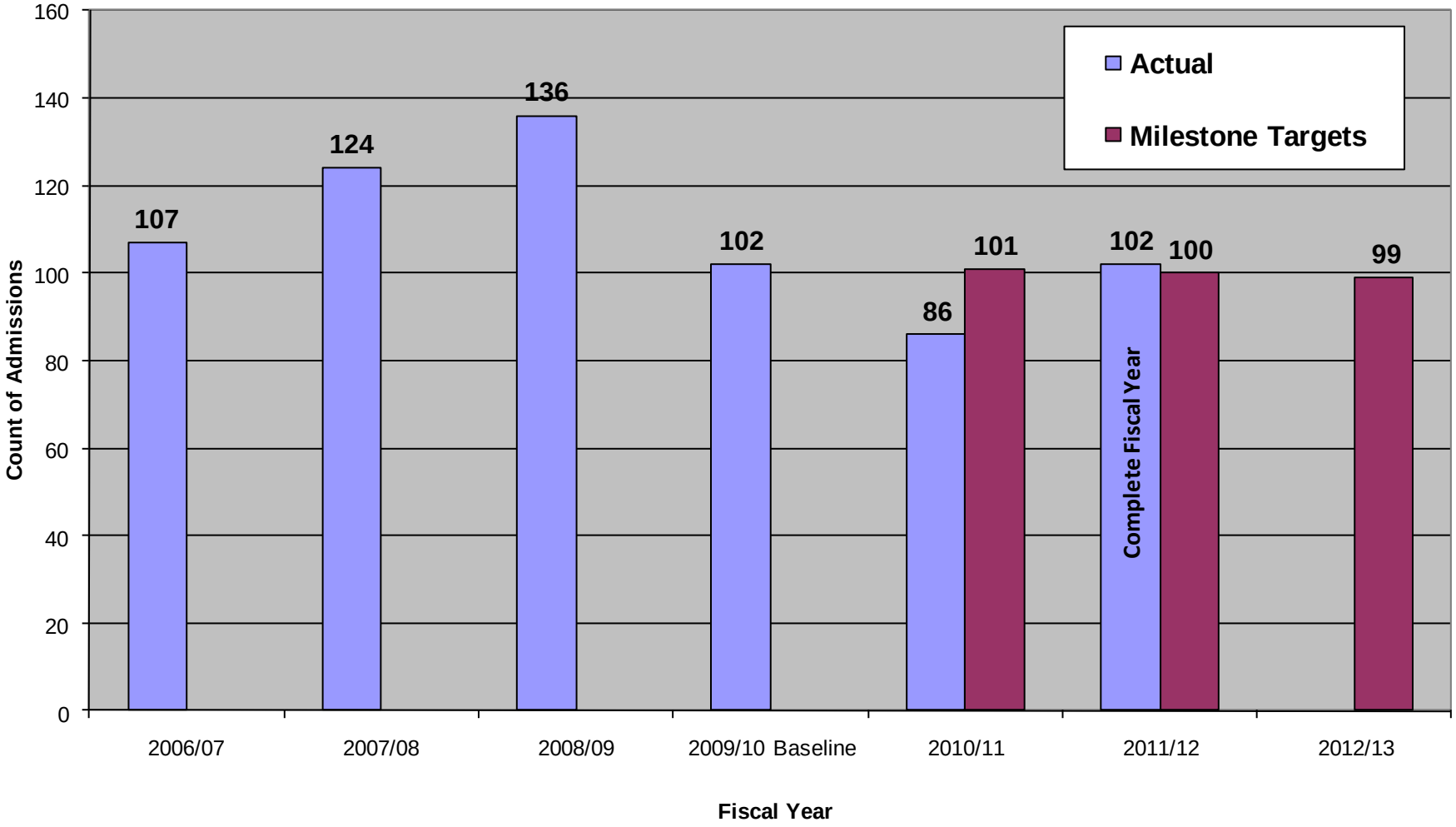
3.2.4 Improved Metabolic Targets for Pre-Diabetes and Diabetes		
Strategic Stream: Sustainability		
Status: △ Caution – awaiting 2011/12 data	Trend: n/a	
Formula: Number of patients with diabetes mellitus in whom the last hemoglobin A1C (HbA1C) was ≤ 7% in the past 15 months divided by the number of Diabetes Care Program of Nova Scotia registered patients.		
Description: To improve outcomes in patients with pre-diabetes and diabetes. The *Our Promise Milestones* are to improve outcomes by 10% in 2010/11, 30% by 2011/12, and 50% by 2012/13. Outcomes include the achievement of metabolic targets for glucose levels in patients involved with management programs.		
Analysis and Progress: Data provided from a report from Diabetes Care Program of Nova Scotia (DCPNS) for patients visiting a Diabetes Management Centre (DMC) within CDHA (Bayer's Road and Cobequid only). The following data are from the outcomes report including newly diagnosed patients only. The cases in the report (234) included newly diagnosed patients who had a visit to the DMC (Jan-Dec 2008) and a follow-up visit between 8 and 15 months after the initial visit (up to March 31, 2010). HbA1C < 7% pre (value in first 3-month period) 109 of 184 cases (59.2%) (baseline) HbA1C < 7% post (value in 8-15 month period) 124 of 159 cases (78.0%) (2010/11 result) The numbers of cases in the pre and post periods differ because of missing data. This shows an increase of 18.8% in the number of patients within the acceptable A1C target—exceeding the 2010/11 target of 10%. A request for an updated report (with the follow-up visit up to March 31, 2011) has been requested from DCPNS but a response has not yet been received. The use of Millennium data is also being explored, but this has been slowed by competing reporting priorities.		
Source: Primary Health Care	Frequency Tracked:	Last Updated: March 2012
Accountability: Barbara Hall		Next Update Expected: 2013

3.2.5 Admissions for Identified Chronic Diseases		
Strategic Stream: Sustainability		
Status: ☒ Did not meet the 2011/12 target	Trend: See graphs	
Formula: Count of hospital admissions where the most responsible diagnosis was chronic obstructive lung disease (COPD); diabetes; or heart failure or pulmonary edema. Admissions to all CDHA facilities are included.		
Description: This indicator is a count of the hospital admissions for which the most responsible diagnosis was chronic obstructive lung disease (COPD); diabetes; or heart failure or pulmonary edema (combined). This excludes admissions for cardiac procedures, deaths before discharge, and patients 75 years or older. These are diseases that can be effectively managed through appropriate ambulatory care. While not all admissions can be avoided, effective community based chronic disease prevention and management programs, self management initiatives, primary care and ambulatory care may prevent the onset of chronic disease, or control or prevent an acute episode or exacerbation. According to the *Our Promise: 2013 Milestones*, the goal is to reduce hospital admissions for identified chronic disease by 1% in 2010/11, by 2% in 2011/12 and by 3 % by 2012/2013. The baseline year is 2009/10.		
Analysis and Progress: The counts of admissions for each of the three chronic diseases listed above are shown in separate graphs below. Each graph shows the total admissions for the 2006/07 to 2011/12 fiscal years, as well as the target admission counts based on percent reductions from the baseline year (2009/10). With a 2.8% reduction in 2010/11, the first-year target of a 1% reduction was met. In 2011/12, for all three diseases combined, there was an *increase* of 5% over the baseline year. This is short of the 2011/12 target of a 2% *decrease*. Individually, none of the diseases met the target. Heart failure or pulmonary edema was the biggest contributor to missing the target for 2011/12. This is linked as a target in the Community Master Plan for Primary Health Care but funding will not allow specific focus on initiatives this year.		
Data Source: Discharge Abstract Database	Frequency Tracked: Monthly	Last Updated: June 2012
Accountability: Barbara Hall		Next Update Expected: July 2012

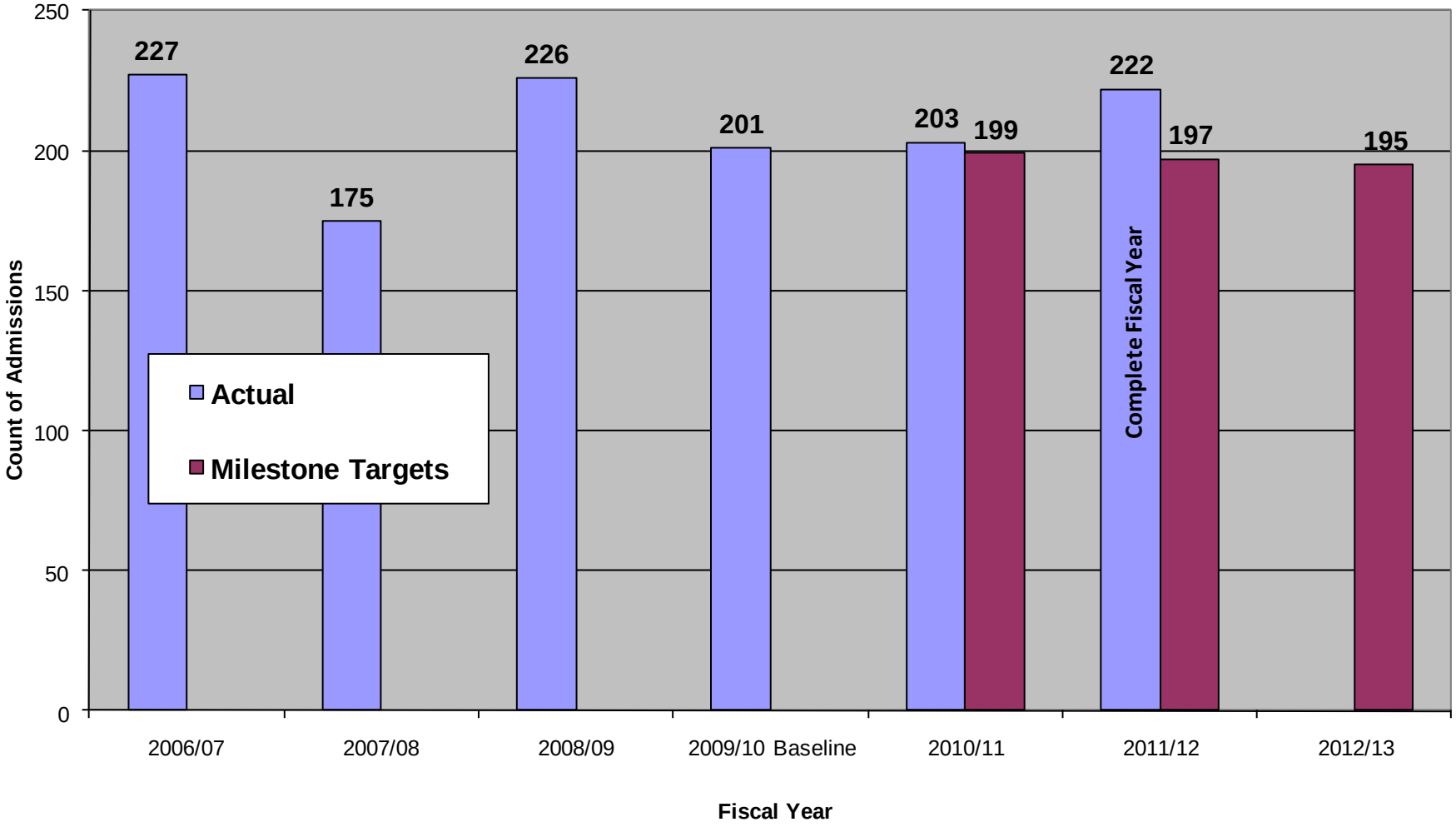
Hospital Admissions for COPD
2006/07 to 2011/12 and Milestone Targets



Hospital Admissions for Diabetes
2006/07 to 2011/12 and Milestone Targets



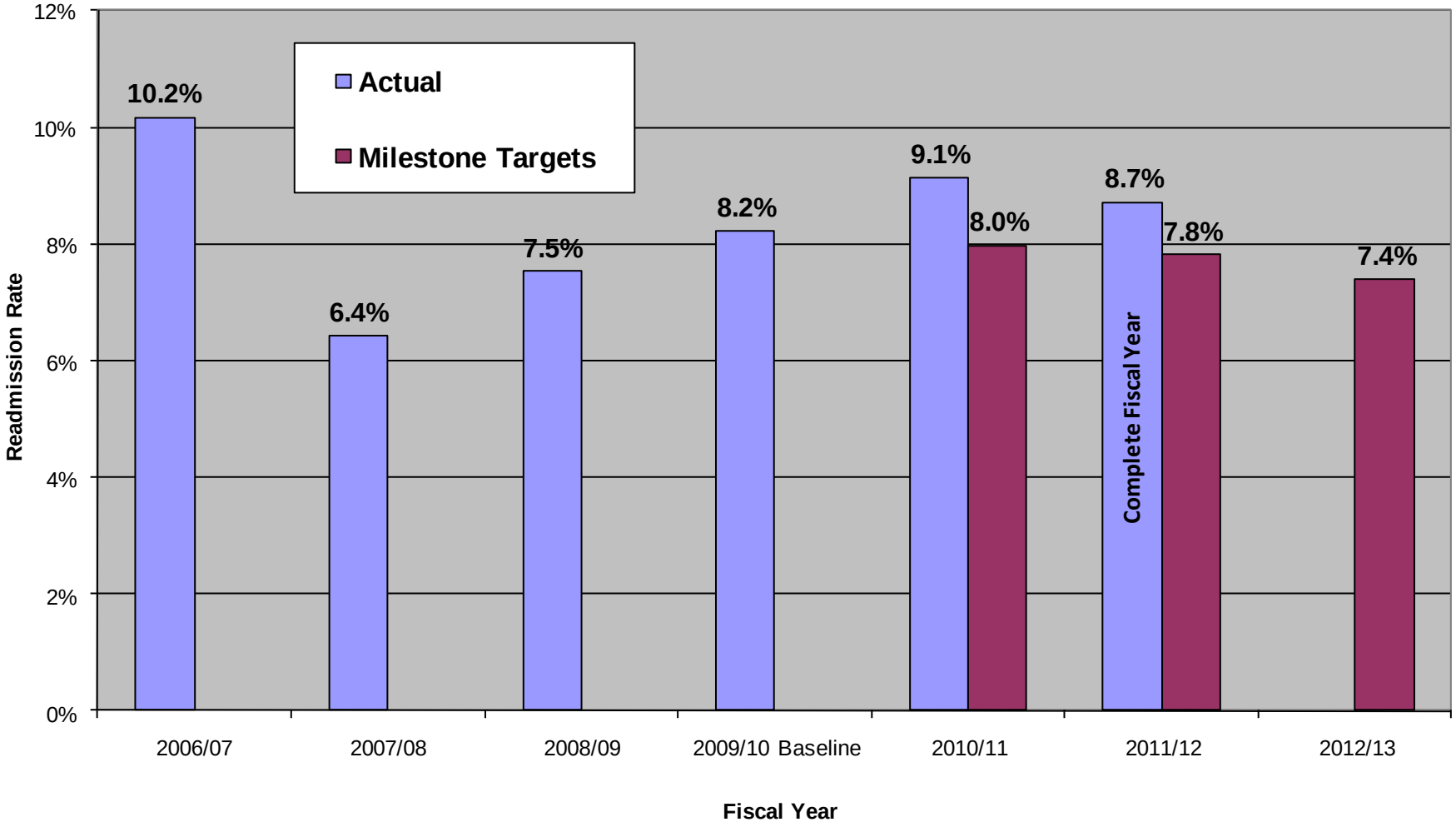
Hospital Admissions for Heart Failure & Pulmonary Edema
2006/07 to 2011/12 and Milestone Targets



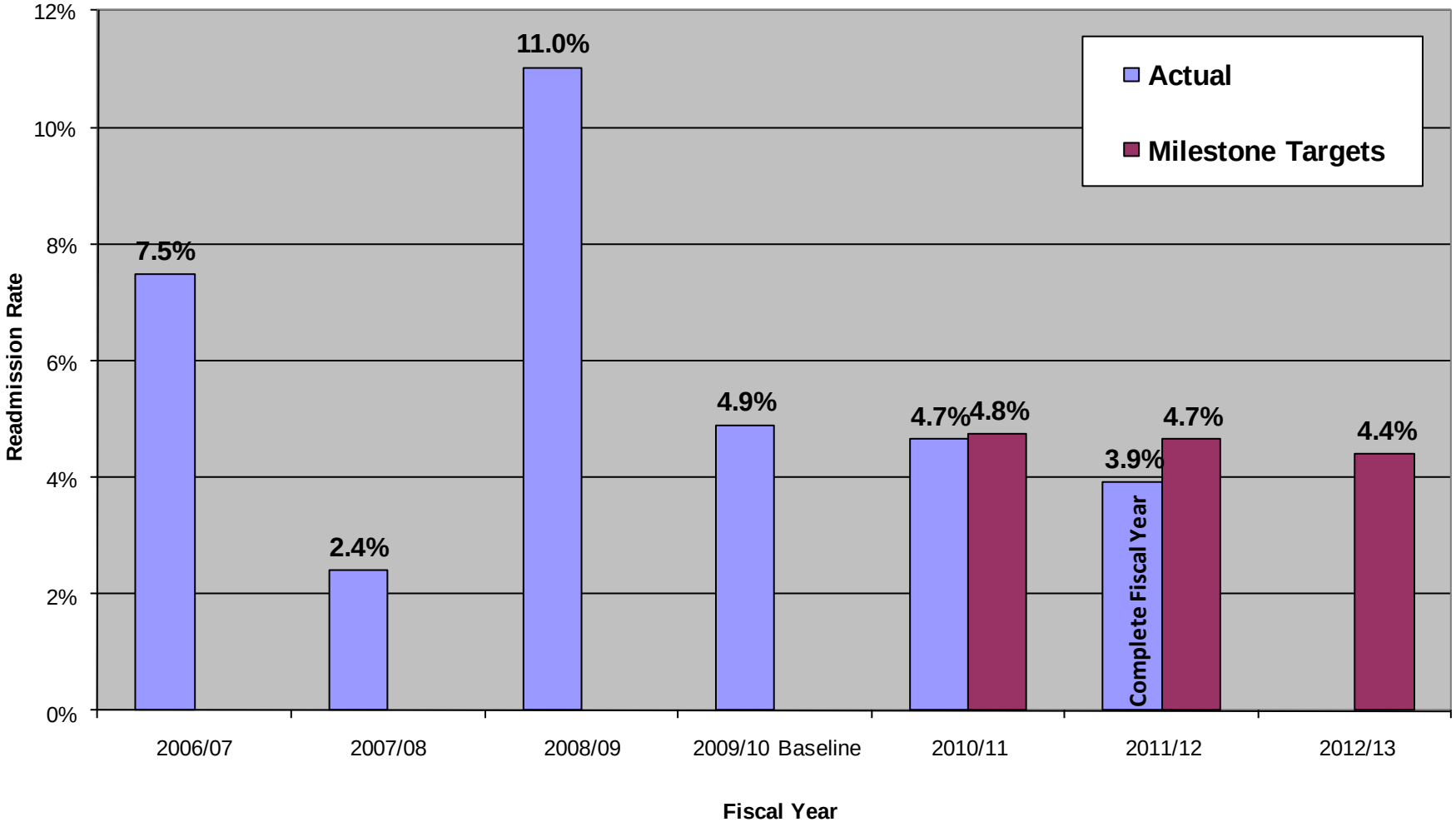
3.2.6 Readmission Rates for Cohorts with Complex Chronic Disease		
Strategic Stream: Sustainability		
Status: ☒Did not met the 2011/12 target	Trend: see graphs	
Formula: Total *readmissions* divided by the total number of *admissions* with the same most responsible diagnosis in the same time period, multiplied by 100.		
Description: This includes readmissions that occur within 28 days of discharge from acute care and within 7 days of day surgery. Readmissions to all CDHA facilities are included. Data are presented for chronic obstructive lung disease (COPD); diabetes; and heart failure or pulmonary edema (combined). Cardiac procedures, deaths before discharge, and patients 75 years or older have been excluded. Patient readmissions may be linked to factors related to the initial hospital stay, prescribing of and compliance with post discharge therapy, or follow-up care in the community. In many cases, readmission can be due to factors outside the influence of the hospital, but high readmission rates should be a trigger for hospitals and primary health care providers to examine carefully their practices, including the possibility of discharging patients too soon and relationships with community-based care providers. According to the *Our Promise: 2013 Milestones*, the goals are to reduce hospital readmission rates by 3% in 2010/11, by 5% in 2011/12 and by 10 % by 2012/2013. The baseline year is 2009/10.		
Analysis and Progress: The readmission rates for each of the three chronic diseases listed above are shown in separate graphs below. Each graph shows the readmission rate for the 2006/07 to 2011/12 fiscal years, as well as the target readmission rates based on percentage reductions from the baseline year (2009/10). In 2010/11, for all diseases combined, the readmission rate decreased by 2.7%, almost meeting the first-year target of 3% In 2011/12, the readmission rate for diabetes met the 2011/12 target, but the rates for COPD and heart failure/pulmonary edema did not. Also for this same time period, all three diseases combined showed a 16% *increase* over the baseline. This is far over the 2011/12 target of a 5% *decrease* from the 2009/10 baseline. The major contributor to this is heart failure/pulmonary edema.		
Data Source: Discharge Abstract Database, Decision Support	Frequency Tracked: Monthly	Last Updated: June 2012
Accountability: Barbara Hall		Next Update Expected: July 2012

Hospital Readmission Rate for COPD

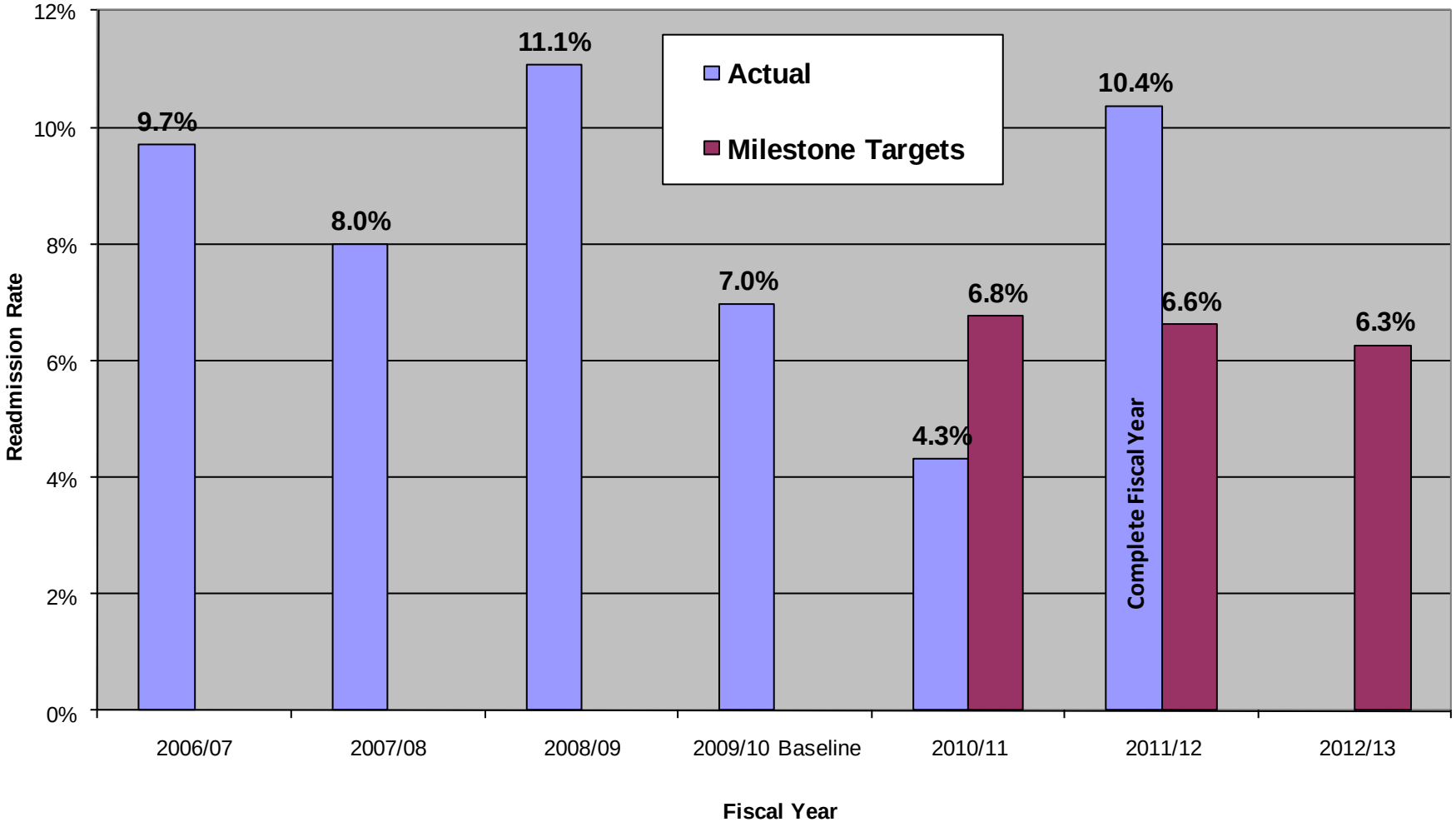
2006/07 to 2011/12 and Milestone Targets



Hospital Readmission Rates for Diabetes
2006/07 to 2011/12 and Milestone Targets



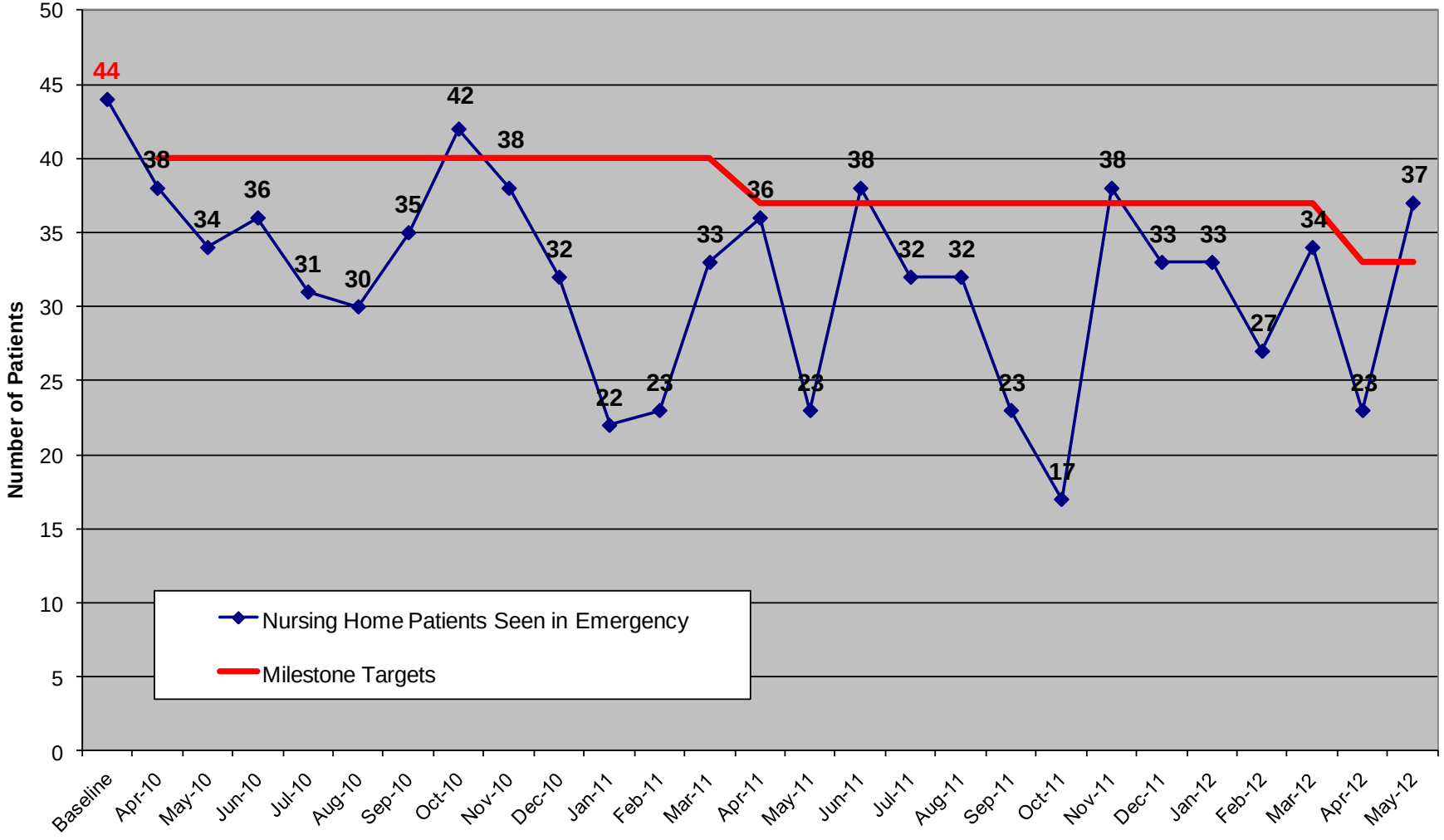
Hospital Readmission Rates for Heart Failure & Pulmonary Edema - 2006/07 to 2011/12 and Milestone Targets



3.2.7 Nursing Home Patients Seen in the Emergency Department		
Strategic Stream: Sustainability		
Status: ☑ Meeting the 2012/13 target	Trend: Decreasing over recent months.	
Formula: Number of nursing home patients seen in the emergency department (ED) in a one-month period		
Description: According to the *Our Promise: 2013 Milestones*, the goals are to decrease the volume of nursing home patients seen in the ED by 10% in 2010/11, by 15% in 2011/12 and by 25 % by 2012/2013. The baseline is the 2009/10 fiscal year, but since collection of these data only commenced in December 2009, a monthly average for the period of January to March 2010 is used as the baseline measure (average of 44 patients per month). The reduction of 10% for the 2010/11 fiscal year translates into a target of 40 nursing home patients per month. The reduction of 15% for the 2011/12 fiscal year translates into a target of 37 patients per month. The reduction of 25% for the 2012/13 fiscal year translates into a target of 33 patients per month.		
Analysis and Progress: The graph below shows the monthly counts of nursing home patients seen in all EDs at Capital Health. The target of 40 was met for 2010/11 when the monthly average was 33. In 2011/12, the target of 37 patients per month (a 15% decrease from baseline) was surpassed, with an average of 31 patients per month (a 30% decrease from baseline). In the first two months of 2012/13, an average of 30 nursing home patients presented to the ED each month. This is so far exceeding the goal of a reduction to 33 per month.		
Source: EDIS, Decision Support	Frequency Tracked: Monthly	Last Updated: June 2012
Accountability: Barbara Hall		Next Update Expected: July 2012

Number of Nursing Home Patients Seen in Emergency Departments per Month

Capital Health - April 2010 to March 2012



3.2.8 Length of Stay - Average Length of Stay for Patients Discharged to Long Term Care

Strategic Stream: Sustainability

Status: No Target	Trend: See graph below

Formula: Average length of stay (days) in hospital for patients discharged to a long term care (LTC) facility

Description: The wait times reported below are for Department of Health and Department of Community Services' patients. The Continuing Care Branch within the Department of Health includes patients who are 65 years of age or over or are under 65 years of age and have nursing level care needs. Halifax Services for Patients with Disabilities within the Department of Community Services includes any patient who is under 65 years of age and requires support / supervision but not nursing level care. Together, they reflect the average wait times for people placed in long term care facilities during that month.

Analysis and Progress: The graph below shows the average length of stay for patients discharged to LTC.

The average length of stay of the mental health population (NSH) is quite variable. This is due to the lower monthly number of patients being placed and the potential for much longer lengths of stay. In order to meet the LTC needs of their patient population, the Mental Health Program works with the Department of Health and Wellness (DoHW) for traditional LTC (nursing home) placements, as well as with the Department of Community Services (DCS) for non-traditional LTC placements such as Adult Residential and Small Options. DCS operates under a different set of rules & guidelines than DoHW and in a more risk averse and cautious manner. This results in Mental Health experiencing a much higher percentage of beds being occupied by patients awaiting placement, by comparison.

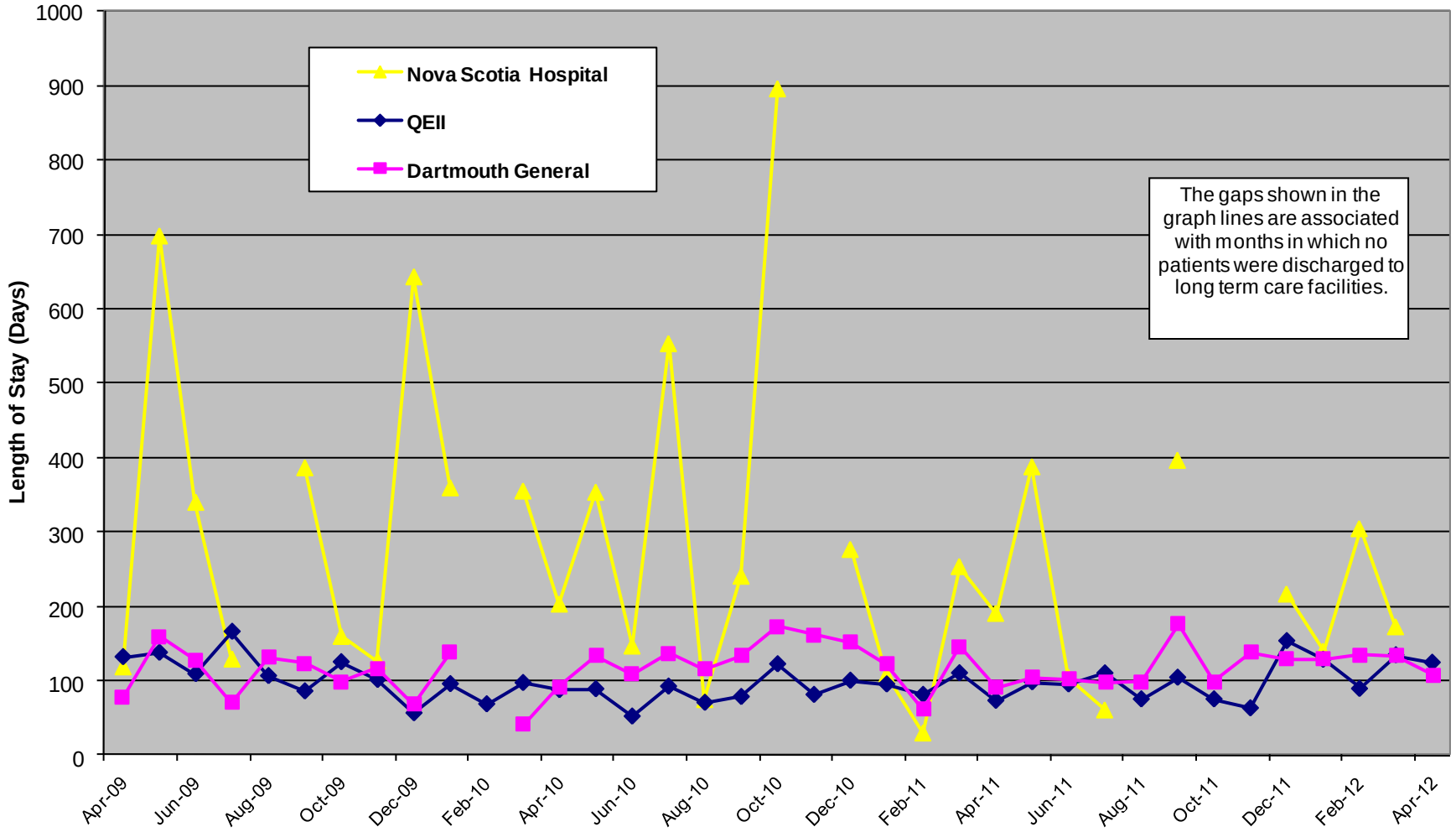
The gaps shown in the graph lines are associated with months in which no patients were discharged to long term care facilities.

It should be noted that lengths of stay are only a snapshot of what is documented in the LTC/ALC database at the time of extraction of data from the database. April 2012 data were extracted on May 16th, 2012.

Source: Social Work	Frequency Tracked: Monthly	Last Updated: June 2012
Accountability: Barbara Hall		Next Update Expected: July 2012

Average Length of Stay for Patients Discharged to Long Term Care

April 2009 to April 2012



3.3 Transformational Leadership

This section contains information and indicators related to employee satisfaction, physician engagement and satisfaction, and quality of work life.

3.3.1 Absenteeism

Strategic Stream: Transformational Leadership

Status: ☒ Not meeting the 2012/13 target	Trend: Improvement over 2011/12

Formula: Average sick hours used per eligible employee per month. Sick hours include paid sick time (NSNU employees), paid general illness (all other employees), short term illness, and grandfather illness long term disability at 100%.

Description: According to the *Our Promise: 2013 Milestones*, the goals are to reduce absenteeism by 5% in 2010/11, by 7% in 2011/12 and by 10% by 2012/2013.

Analysis and Progress: A graph of the average sick hours per eligible employee at CDHA is shown below.

In 2010/11, average sick hours *increased* 2.8% from the baseline year and the target was not met. For the full 2011/12 fiscal year, average sick hours were 3.0% *higher* than the baseline. In the first month of 2012/13, average sick hours were 7.6% lower than the baseline.

Healthy Workplace along with Wellness and Safety services have combined forces to provide educational programs for frontline managers to enable them to recognize signs of workplace fatigue attributed to stress. An October 2011 workshop on mental health at work was scheduled as education for senior leaders. Communications have been sent to employees thanking them for their attendance, while ensuring accountability around sick time usage.

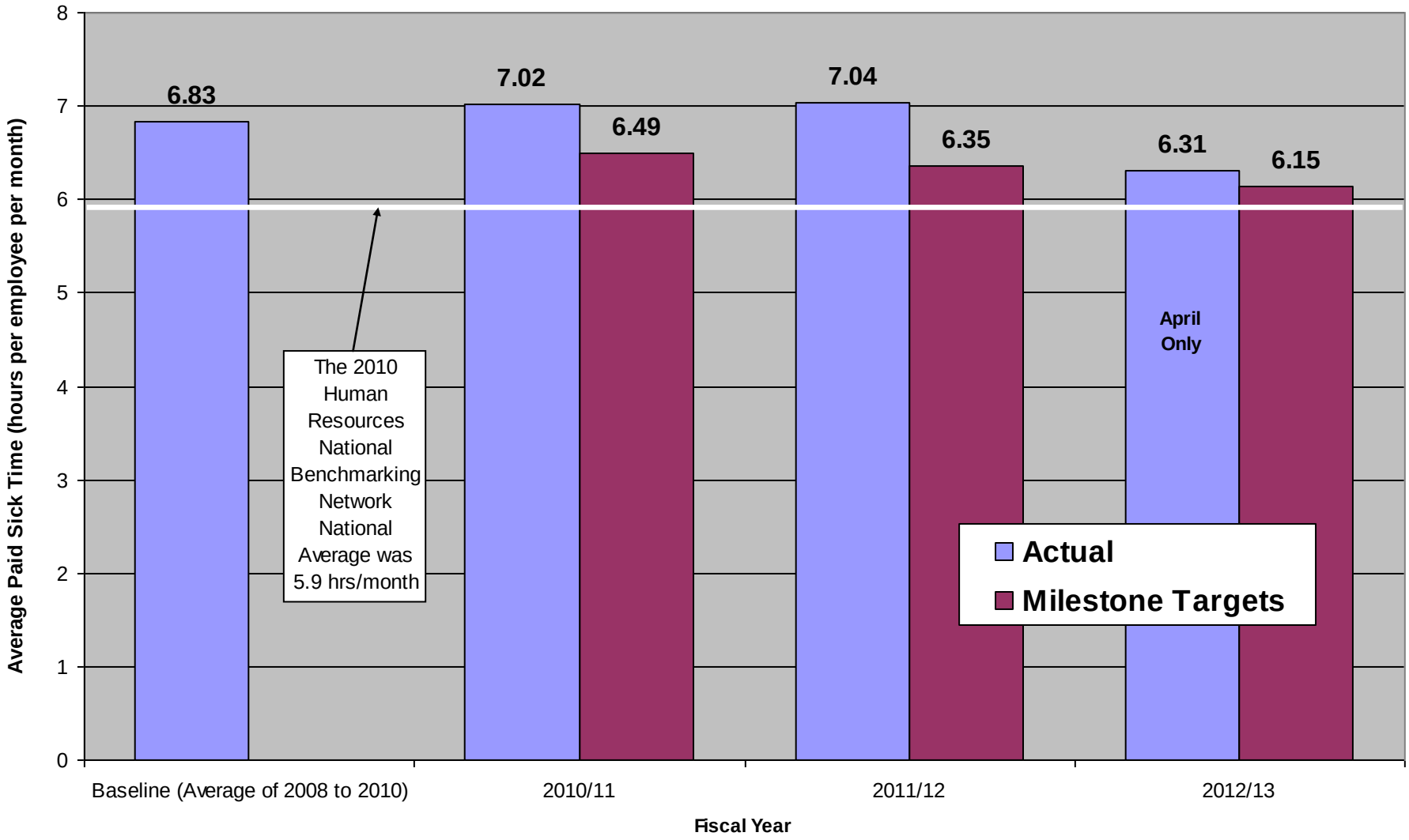
People Services has also teamed up with Wellness and Safety to help deliver education opportunities to assist managers with the utilization of employment contracts around culpable sick time, improving accessibility by means of identification/promotion of services. Relevant quality operational indicators are being identified and will be used to determine the best services available to meet these goals.

Although the indicator for this period is not meeting target, it is closing in. Traditionally there is high absenteeism for the first quarter of any year; however, in both July and August there was a significant drop in absenteeism compared to April, May, and June.

Source: People Services	Frequency Tracked: Monthly	Last Updated: June 2012
Accountability: Kathy MacNeil		Next Update Expected: July 2012

Monthly Average Paid Sick Hours per Eligible Employee at CDHA

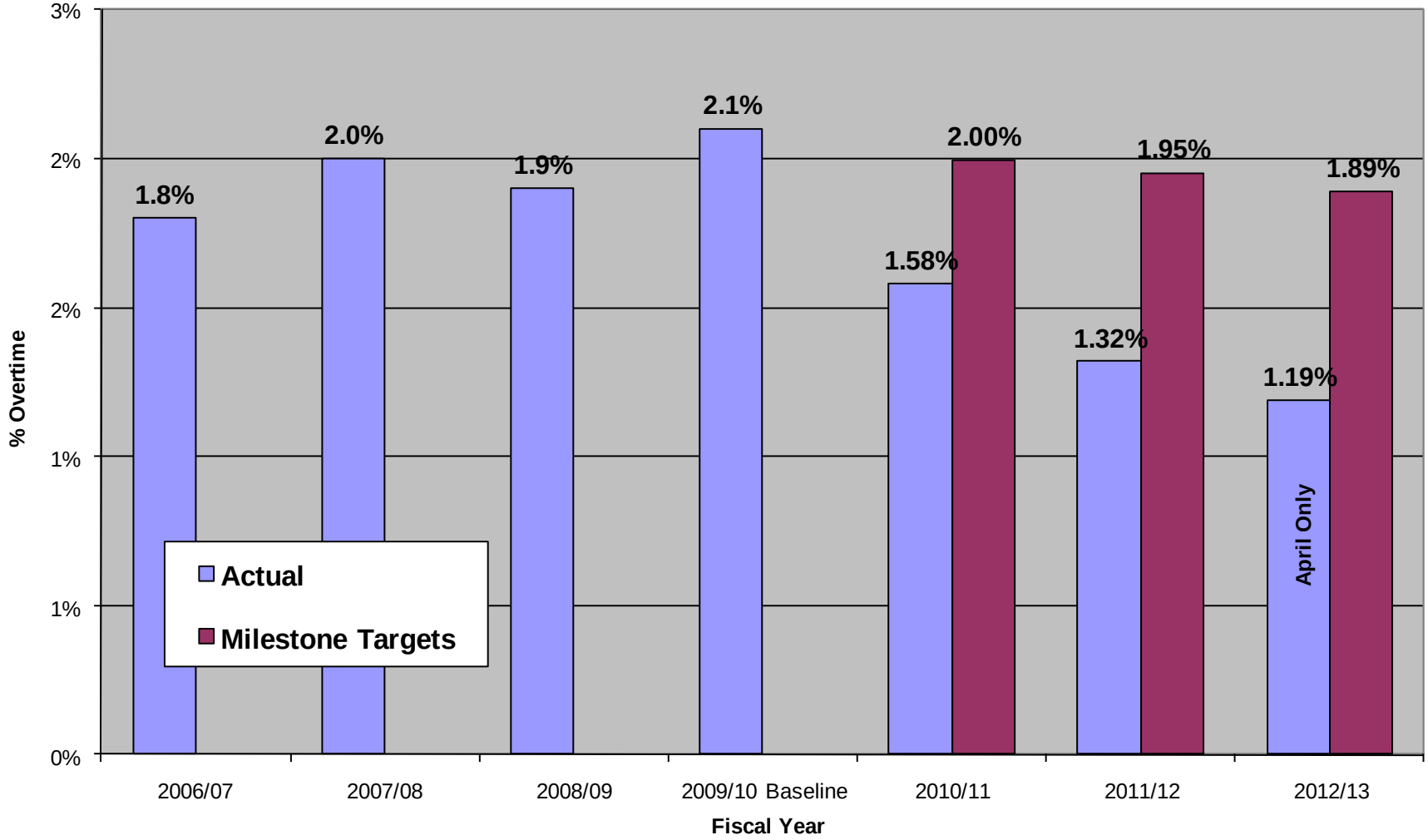
2009/10 to 2012/13 Year to Date and Milestone Targets



3.3.1 Overtime – Percent of Overtime Hours Worked		
Strategic Stream: Transformational Leadership		
Status: ☑ Met the 2011/12 target and on track for 2012/13	Trend: Decreasing (favourable)	
Formula: Total hours worked overtime divided by the total hours worked, multiplied by 100.		
Description: According to the *Our Promise: 2013 Milestones*, the goals are to reduce overtime by 5% in 2010/11, by 7% in 2011/12 and by 10% by 2012/2013. The baseline year is 2009/10, in which 2.1% of worked hours were overtime hours.		
Analysis and Progress: The graph below shows the percentage of overtime worked at CDHA for the fiscal years 2006/07 to 2012/13 and milestone targets. In 2010/11, 1.58% of hours worked were overtime hours. This was a decrease of 25%—surpassing the target of a 5% decrease. For 2011/12, the percentage of overtime hours worked was 1.32%. This is a 37% decrease from the baseline—surpassing the 2011/12 target of a 7% decrease. In the first month of 2012/13, the percentage of overtime hours worked was 1.19%, a decrease of 43% from baseline. If this trend continues for the rest of the fiscal year, the target of a 10% reduction will be far surpassed. Over the last several years there have been several initiatives put in place to help reduce OT such as increased hiring of grad nurses in 2008, 2009 and 2010; increased education on understanding financials; central staffing office; and stream-lined staffing processes at the QEII.		
Source: People Services	Frequency Tracked: Monthly	Last Updated: June 2012
Accountability: Kathy MacNeil		Next Update Expected: July 2012

Percentage of Overtime Hours Worked at CDHA

2006/07 to 2012/13 and Milestone Targets



3.3.2 Recruitment for Hard-to-Fill Positions

Strategic Stream: Transformational Leadership

Status: ☑ Has met the 2011/12 target	Trend: There has been an increase in the time required to fill vacancies due to business planning and trying to reduce hiring rather than lack of applicants. There has been an increasing difficulty in the hiring of LPNs.

Formula: The number of employees recruited to specified hard-to-fill positions divided by the number of specified hard-to-fill positions referred to the recruitment team

Description: According to the *Our Promise: 2013 Milestones*, the goals are to improve recruitment by 10% in 2010/11, by 30% in 2011/12, and by 50% by 2012/2013. The baseline year is 2009/10. The information related to hard-to-fill positions is one component of this measure.

Targeted hard-to-fill positions include:

- Nurses (particularly in specialty areas such as emergency, perioperative, critical care, and in locations outside Metropolitan Halifax)
- Healthcare professions that require specialty / post graduate or additional studies (ORTs + perfusionist)
- Managerial positions (Chief Medical Physicist)

Analysis and Progress: The procedure for handling hard-to-fill positions continues, i.e., conducting a focused search if a position remains unfilled after the posting obligations have been met in accordance with our collective agreements.

Although some external advertising has been used to expand outreach, there has been no vacancy referred for additional recruitment efforts since last report submitted in February 2012.

As of April 30, 2012, there were 350 open positions—74 of which were opened in 2011. These are either pooling or at different stages of being closed. There were 276 postings opened in 2012 (75 RNs + 2 managerial+ 20 LPNs). Only 45 of them exceeds the 90 days of hard-to-fill definition.

- 19 RN
- 1 managerial
- 2 LPN

Source: People Services	Frequency Tracked: Quarterly	Last Updated: May 2012
Accountability: Kathy MacNeil		Next Update Expected: August 2012

3.3.3 Alignment of Medical Departments and Operational Structures

Strategic Stream: Transformational Leadership

Status: ☑ On Track to meet the 2012/13 target	Trend:

Formula: The number of medical departments aligned with operations.

Description: According to the *Our Promise: 2013 Milestones*, the goal is to have 40% of medical department structures aligned with operations by 2010/11, 60% by 2011/12, and 100% by 2012/2013. Aligning medical and operational structures will facilitate organizational change and support achievement of organizational goals

Analysis and Progress: Physician Services in consultation with physician leaders has determined that five Key strategic initiatives must be implemented and be achieving set targets as a condition of meeting this milestone. Those 5 areas are:

1. Departmental Governance, Structure, payment principles and accountability aligned with the CDHA as required
2. Leadership accountabilities defined and assessed with a process in place to address performance and ongoing development (leadership development, Co-leadership Implementation)
3. Departmental Search and Survey process alignment
4. Academic Funding Plan Framework redesign work
5. Departmental Quality activities aligned with organizational practices and priorities

Activities and achievements to date tell us that we are on target to meet the 2013 milestone target of 100% alignment of department structures and operations with CDHA organizational goals

Performance Measures/Indicators:

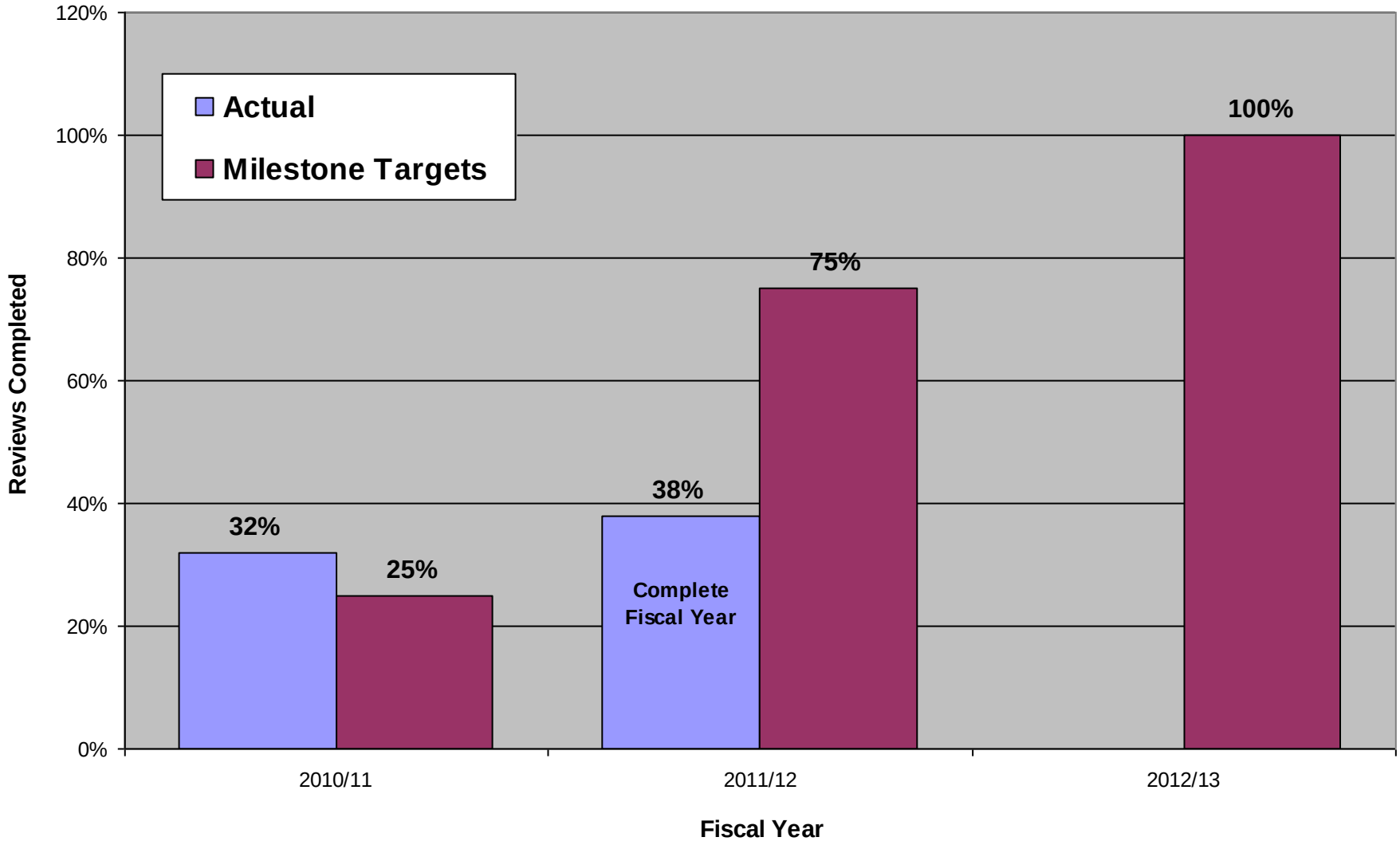
- 100% of Medical Departments are constituted and operate in accordance to the CDHA Medical Staff Bylaws
- 17 out of 20 co-leaders reported co-leadership relationships have advanced. Specifically, decision making, trust between co-leaders, shared vision and accountabilities, frequency of meetings and increased appreciation and respect of one another.
- 26 physicians enrolled in second cohort of the FATT *physician leadership program.*
- 86% of available seats in the second Cohort of FATT Leadership Program were filled.
- 100% of physicians in Cohort 2 completed the FATT *leadership program*.
- 97% of participants in FATT *leadership program* reported they were "overall satisfied with the program"
- 100% of medical departments requiring a survey have been completed.
- 93% of medical departments requiring a survey are completed on time in accordance with the survey cycle.
- 60% of medical divisions within departments requiring a survey have been completed.
- 40% of medical divisions within departments requiring a survey are completed on time in accordance with the survey cycle. (others were stalled for justified reasons)
- 100% of AFP departments have a Practice Plan reviewed by the District to ensure alignment with organizational priorities
- 75% of non-AFP departments have a practice plan (or equivalent) demonstrating alignment with CDHA organizational priorities.

Source: Physician Services	Frequency Tracked: Varies	Last Updated: June 2012
Accountability: Ray LeBlanc (Interim VP Medicine)		Next Update Expected: November 2012

3.3.4 Compliance with Performance Evaluation Process		
Strategic Stream: Transformational Leadership		
Status: ☒ The 2011/12 target was not met	Trend: Increasing from 2009/10 and 2010/11 (favourable)	
Formula: All employees with performance appraisals completed plus those not yet due, divided by the total number of active employees (multiplied by 100 to get a percentage).		
Description: According to the *Our Promise: 2013 Milestones*, the goals are to bring compliance with performance appraisals to 25% in 2010/11, to 75% in 2011/12, and to 100% by 2012/2013. Performance appraisals should be completed for union-member employees a minimum of every two years. In September 2010 the organization began to require performance appraisals annually for excluded confidential and management employees. Performance appraisals are only recorded as received when they are placed in the employee's file.		
Analysis and Progress: Management and confidential excluded employees are required to have a completed performance appraisal on file before merit increases are processed. The quarterly performance appraisal progress report is distributed following the end of each quarter. This distribution provides managers, directors, and VPs with a status report and assists with quarterly planning. Scorecard results are also posted in the intranet. To increase the number of actual performance appraisals being done, and to ease the administrative burden associated with the process, which is all manual, a shortened revised Performance tool, that was developed in conjunction with operations managers, was posted on the Internet for use as of June 2011, and the operations groups are now using it to complete the appraisals with their staff. HR consultants continue to support managers in completing the process and with ongoing training. A shared accountability between People Services (process) and Transformation Network Team (content) supported by Performance Excellence to create web-based (Select Survey) performance tools and processes for management and excluded/union positions. This project incorporates Capital Health's leadership capabilities into the tools, allowing for ease of distribution, completion and collation at no additional cost to better strengthen achievement of the milestones within the Transformational Leadership strategic stream. Plans are to prototype the new tools with VP and Director levels in February/March 2012 with an organizational rollout in early 2012-13. The graph below shows the percentage of performance appraisals completed for fiscal years 2010/11 to 2011/12. The target of 25% for 2010/11 was exceeded. In 2011/12, 38% of performance appraisals were completed—falling short of the 75% target.		
Source: People Services	Frequency Tracked: Quarterly	Last Updated: April 2012
Accountability: Kathy MacNeil		Next Update Expected: July 2012

Staff Performance Reviews Completed at CDHA

Fiscal Years 2010/11 to 2011/12 and Milestone Targets



<table>
<tr><td colspan="3">3.3.5 Formal Leaders Demonstrate Transformational Leadership Capabilities</td></tr>
<tr><td colspan="3"><u>Strategic Stream:</u> Transformational Leadership</td></tr>
<tr><td colspan="2"><u>Status:</u> Not known – annual measure not yet completed</td><td><u>Trend</u>: Positive for 2 of 3 measures. See graph and analysis.</td></tr>
<tr><td colspan="3"><u>Formula:</u> The number of leaders demonstrating transformational leadership capabilities as defined by My Leadership within the time period.</td></tr>
<tr><td colspan="3"><u>Description:</u> According to the Our Promise: 2013 Milestones, the goal is to have 50% of leaders consistently demonstrating the My Leadership transformational leadership capabilities by 2010/11, 75% by 2011/12, and 90% by 2012/2013. Results are based on evaluations pre/post organizational change.</td></tr>
<tr><td colspan="3"><u>Analysis and Progress:</u> A new My Leadership program has been launched for teams of front line staff. Over 1600 participants have begun this program including 595 who have completed it, with participant evaluations at 78 - 98% positive on four measures including:

• 95% agree / strongly agree with: “I understand the need for change in health care and why I need to be a part of that.”
• 98% agree / strongly agree with: “I understand that if we want a different outcome we must be prepared to do something different.”
• 85% agree / strongly agree with: “I understand what it means to be a leader and that it’s going to take all of us as leaders to succeed.”
• 78% agree / strongly agree with: “I feel inspired to be an active player and to step into the leadership that I can provide.”

A new module for director / manager teams has also been launched and participant evaluations are similarly high at +95% positive on 8 measures (n=99) including:

• 100% agree / strongly agree they have explored their team’s aspiration to high functioning leadership.
• 98% agree / strongly agree they have furthered their personal leadership development by focusing on the team.
• 95% agree / strongly agree they have gained clarity about their accountability for advancing the team’s leadership.”

The My Leadership program for formal leaders was launched in April 2009 and it is clear from the employee survey data that transformational leadership behaviours did increase between 2009 and 2011. Employee survey results show that leader performance has risen on the dimensions of Being (66%) and Doing (70%). Results on the Caring (64%) dimension in 2011 were slightly lower than in 2009. Overall, 2011 survey results on all three dimensions exceed the interim target of 50% established for fiscal year 2010-11. New measures of this indicator have not yet been completed (planned for September 2012). Evaluations from formal and emerging leaders remain high at greater than 90% positive on 13 measures (n=612).</td></tr>
<tr><td><u>Source:</u> Neale Bennet</td><td><u>Frequency Tracked:</u> Variable</td><td><u>Last Updated:</u> May 2011</td></tr>
<tr><td colspan="2"><u>Accountability:</u> Kathy MacNeil</td><td><u>Next Update Expected:</u> Fall 2012</td></tr>
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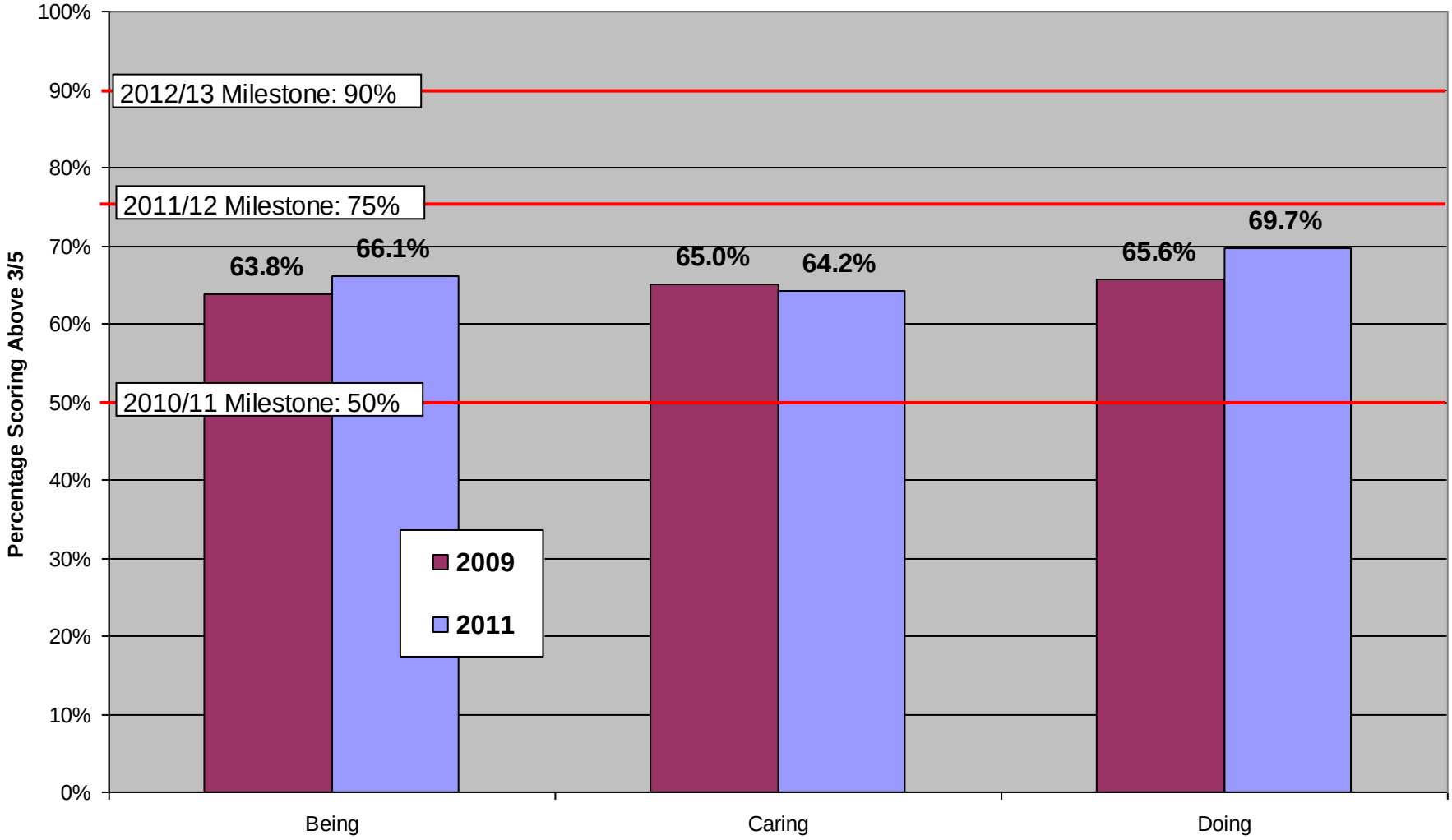
Capital Health Employee Survey Results
2009 & 2011 and Milestone Targets



3.3.6 Employee Survey

Strategic Stream: Transformational Leadership

Status: No set target	Trend: see graph

Formula: Percentage of favorable, neutral, and unfavorable responses in a given section of the survey

Description: At Capital Health, we have made a promise to be a world-leading haven for people-centred health, healing, and learning. We can only achieve Our Promise if each of us experiences Capital Health as a rewarding, satisfying, and healthy place to work. That's why every two years, an employee survey is conducted. The survey, conducted in February 2011, allows the measurement of progress and the answers the following questions: How are we doing? Where could we be doing better? What will we celebrate?

The response rate was 46%.

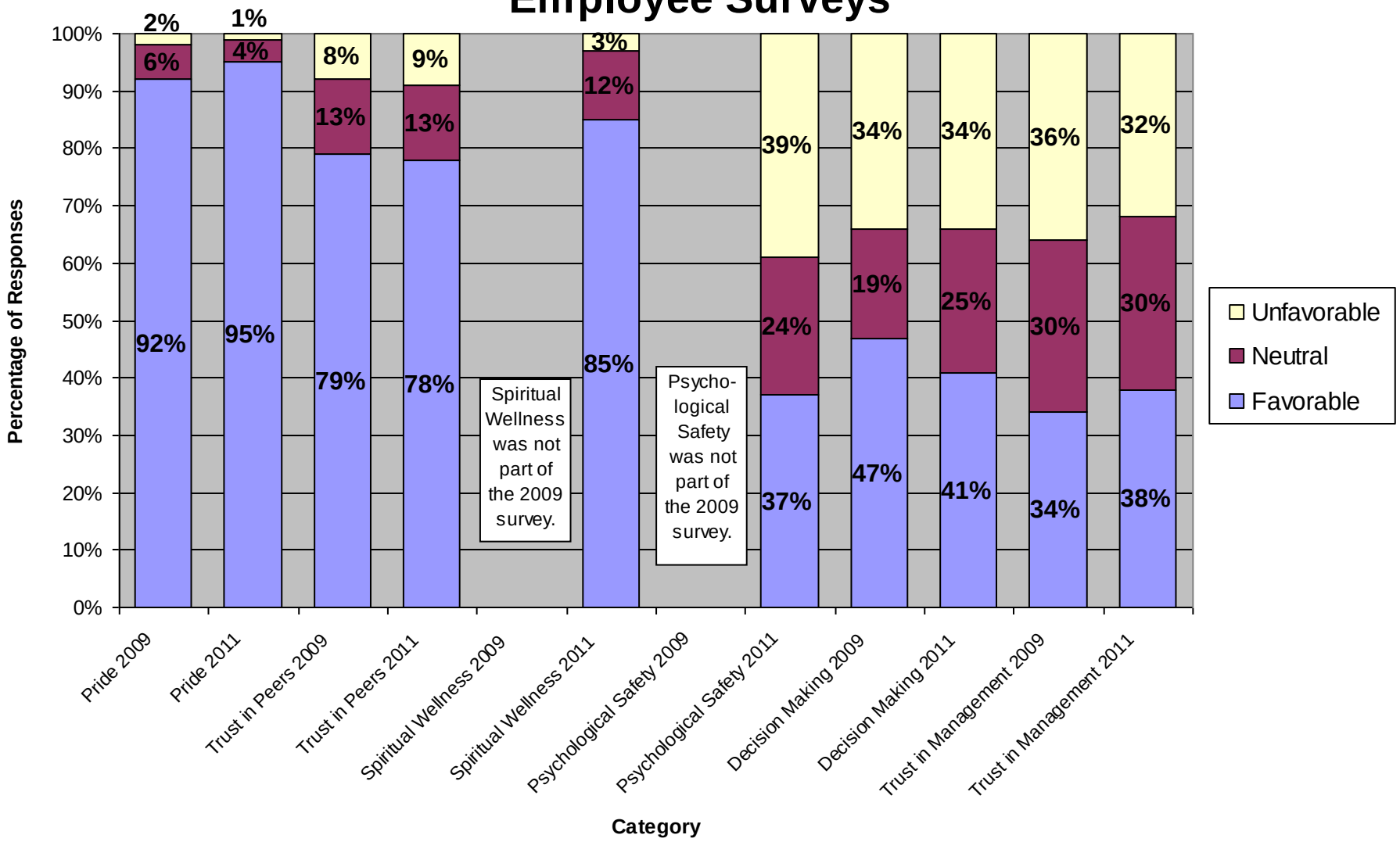
Analysis and Progress: The graph below shows a selection of the results of the 2009 and 2011 Capital Health Employee Surveys. The selection of results presented in this report are meant to highlight a sample of areas to be celebrated and areas where improvements could be made.

From the graph it can be seen that both pride and trust in peers had very high percentages of favorable responses in both 2009 and 2011. Spiritual wellness was not part of the 2009 survey, but had a very high percentage of favorable responses in 2011. Some of the areas for improvement include psychological safety, involvement in decision making, and trust in management.

Teams throughout Capital Health will receive team reports in June 2011, have conversations, and implement action on ways to improve their workplace. This process is the most meaningful for staff as each unit or department is unique and will have unique interests and ideas that the organizational response to survey results may not address. The 2011 survey team will make one to two recommendations based on analysis of the organizational survey results—looking at statistical and practical significance of the results and the relationships among the survey measures. The team will look for leverage opportunities based on this analysis and the prospect of alignment with existing or planned strategies within Capital Health and our larger community.

Source: People Portfolio	Frequency Tracked: Every two years	Last Updated: June 2011
Accountability: Kathy MacNeil		Next Update Expected: 2013

Selected Results From the 2009 & 2011 Employee Surveys



3.3.7 Physician Survey

Strategic Stream: Transformational Leadership

Status: No set target	Trend: n/a

Formula: Percentage of favorable, neutral, and unfavorable responses in a given section of the survey.

Description: The 2011 Capital Health Physician Survey was created by Physician Services in consultation with several department chiefs, and the presidents of both DMSA and DMAC. In January and February 2011, physicians from all medical staff categories (active, resident, fellow, associate, consulting, courtesy, clinical associate, clinical trainee, and locum tenens) were invited to complete a survey. The survey data were collected through ClearPicture, an independent survey firm. The response rate was 54%.

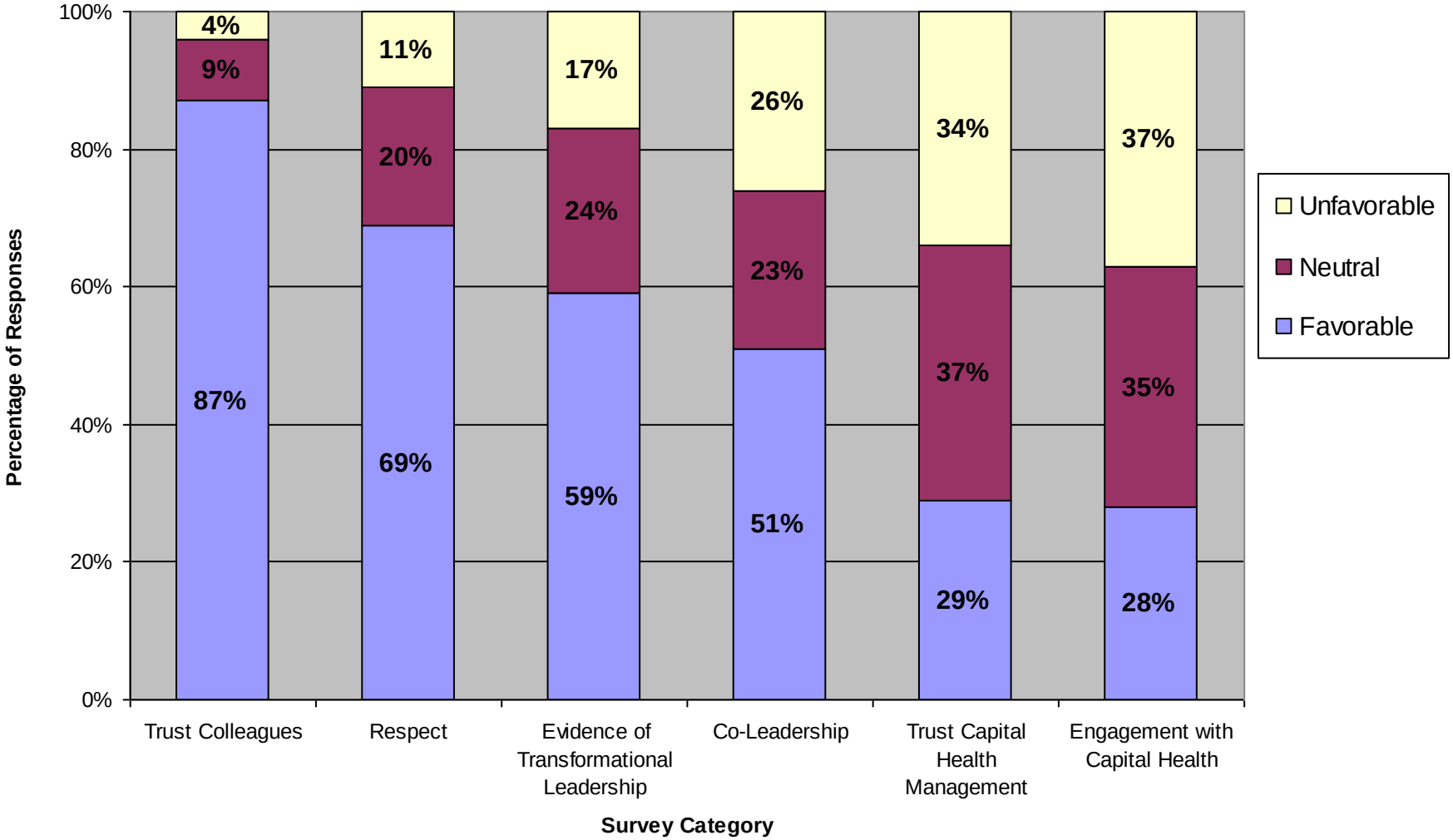
The information uncovered through this survey process will assist Capital Health in further developing and strengthening relationships with physicians for the sake of improved patient centered care.

Analysis and Progress: The graph below shows the results for six selected sections of the physician survey. Of the six shown, trust in colleagues and respect had the highest percentages of favorable responses, while trust in Capital Health management and engagement with Capital Health had the lowest percentages of favorable responses. Transformational leadership and co-leadership fell in between.

Initiatives such as Co-Leadership have been established to increase physician involvement in leadership at Capital Health. Co-Leadership work focuses on improving relationships for the sake of improved performance. Novel development work was recently presented at the Canadian Association for Health Services and Policy Research Annual Conference. The Fully at the Table program is still offered and is the focus of a national research investigation exploring ways to advance leadership for the sake of improving health care.

Source: Physician Services	Frequency Tracked: Every two years	Last Updated: June 2011
Accountability: Ray LeBlanc		Next Update Expected: 2013

Selected Results from the 2011 Capital Health Physician Survey



3.4 Citizen Engagement and Accountability

This section contains a number of indicators focused on measuring levels to which patients/families are involved in decision-making, demonstrated openness and transparency as an organization and; progress on actions taken to effect societal change.

3.4.1 Receipt of Health Passport

Strategic Stream: Citizen Engagement and Accountability

Status: ☒ Did not meet the 2011/12 target	Trend: n/a

Formula: Monitoring is currently in development

Description: Health Passports are designed to assist patients in understanding and communicating their health status. Passports are ideally developed before patients interact with healthcare providers. Capital Health will promote passports by assisting patients to develop, own and maintain their own health information through the use of MyHealth Passports. The use of a passport should improve patient self confidence in managing chronic disease.

The goals, as outlined in the *Our Promise: 2013 Milestones*, have been amended to target community clinics rather than non-palliative discharges. Adoption objectives are under review.

Analysis and Progress: The Health Passport Steering Committee has determined passports are best suited for chronic disease populations in clinics and the community Capital Health/IWK have partnered with the SickKids Hospital in Toronto to share their existing web-based patient passport site. Capital Health officially launched its MyHeath Passport in September with presentations during Capital Health Community Days and internal information sessions. The link has been added to the public site and posters distributed broadly. There have been 300+ hits to the passport site from October 2011 to February 2012.

Efforts will now focus on communication and engagement of groups that are best positioned to promote the passport (e.g. community and primary health care). Both Public Health and Primary Care have been approached to be clinical leads/owners of this initiative but neither group feels they have the capacity to take this role on at this time.

Source: Finance & Decision Support	Frequency Tracked: Quarterly	Last Updated: June 2012
Accountability: Paula Bond		Next Update Expected: September 2012

3.4.2 Influence Change in Three Major Public Policies	
Strategic Stream: Citizen Engagement and Accountability	
Status: ☑ Met the 2011/12 target	Trend: Improvement over 2009/10 baseline; work is ongoing
Formula: Number of major public policies influenced through Capital Health advocacy.	
Description: Adoption of patient-centered, health-prevention public policies aimed at improving patient health. The *Our Promise: 2013 Milestones* goals are to influence one major policy by 2010/11, a second by 2011/12, and a third by 2012/13. The targeted policies are: tobacco use, food security, nutrition in schools/day care settings. **Section continued on next page**	

Analysis and Progress: **Tobacco Use:** Public Health initiated action within Capital Health to strengthen and enlarge health warnings on cigarette packages in December 2010. Barb Hall and Gaynor Watson-Creed supported Chris Power to send letters of support to NS MPs and to Prime Minister Harper advocating for enlarged and stronger messaging regarding health warnings on tobacco products. The effort was part of a national advocacy strategy by health groups which was successful and resulted in the government announcing enlarged and stronger messaging as part of their renewed approach to tobacco control. The level of NS advocacy was noted in Ottawa, making us part of the success story. Capital Health actively supported the development and release of the new Tobacco Control Strategy for Nova Scotia, *Moving Toward a Tobacco-free Nova Scotia.* The April 6th Throne Speech included, "Later this spring, a renewed Tobacco Strategy will be launched." The Strategy was released April 27, 2011.

Food Security: In 2010/2011, Capital Health played a major role in year one of the Activating Change (ACT) for the Community Food Security Community University Research Alliance (CURA) research project. ACT for Community Food Security is a five-year research project rooted in lived experiences, real community needs and innovative solutions and aims to strengthen capacity for policy change that will build food security. Although no policies have been affected directly thus far, it is expected that the work completed to date, in tandem with other policy-related food security work (i.e. NS Participatory Food Costing Project), will create the conditions for policy to affect all levels of government that will contribute to a more food-secure Nova Scotia. Capital Health continues to play a role in the Nova Scotia Participatory Food Costing Project. Data is submitted to inform increases to minimum wages and income assistance rates in Nova Scotia. The most recent data was released in May 2011.

- Several members involved in the CURA are going to participate in the UN special mission on the right to food in May. The CURA also influenced the 5 issues being focused on :
    1. *Economic accessibility, as a condition for the enjoyment of the right to food, particularly for the poorest segments of the population, and the impact of poverty on the adequacy of diets;*
    2. *Aboriginal peoples and the right to food;*
    3. *The organization of food chains and its impact on the right to food;*
    4. *Governance of policies and programs that impact the right to food, including social protection programs; and*
    5. *International development cooperation, food aid and the right to food.*
- CURA and food costing project participated in a presentation to the Standing Committee on Department of Community Services. The focus was income along with trying to highlight the complexity of food and issues surrounding it.
- There was involvement and contribution from those in the CURA on the development of the newly release provincial Childhood Obesity Prevention Strategy

Nutrition in Schools/Day Care Settings: Public Health and Capital Health collaborated with government, child care centres, and training institutions to research, develop, and implement the Nova Scotia Standards for Food and Nutrition in Regulated Child Care Settings. The Food and Nutrition Standards were effective as of July 1st 2011. The comprehensive Standards were developed to support child care providers in creating an environment that supports all children in developing healthy eating patterns and behaviours. Public Health continues to support the Standards by collaborating with the Departments of Community Services and Health and Wellness and external partners to provide training opportunities and resources related to the Food and Nutrition Standards.

Source: Public Health	Frequency Tracked: Quarterly	Last Updated: May 2012
Accountability: Barbara Hall, Gaynor Watson-Creed		Next Update Expected: Summer 2012

3.4.3 Access for Underserved / Vulnerable Groups		
Strategic Stream: Citizen Engagement and Accountability		
Status: △Caution: measurement of indicator is in progress	Trend: n/a	
Formula: Indicator is under development. Each year, identify all programs and targeted groups that are under consideration; report on those programs that are to be implemented/continued within that year.		
Description: Vulnerable groups are defined as per the social determinants of health (income, education, culture, and gender). This work is targeting groups such as: • Gay, Lesbian, Bisexual, Transgender, Intersex (Pride Health) • Homeless (Insecurely housed or street workers) • African Nova Scotia Communities • New Immigrant Populations • Mental Health The *Our Promise: 2013 Milestone* goals are to improve access for vulnerable and underserved groups by 10% in 2010/11, by 15% in 2011/12, and by 25% in 2012/13.		
Analysis and Progress: Capital Health is supporting programs such as Mobile Outreach Street Health and wellness clinics in underserved areas such as North Preston. Primary Health Care is working with Community Health board coordinator and Cobequid Community Health Centre to plan a health forum in Pockwock/Lucasville. Pride Health will be further focusing efforts on the transgender population. Work to support new immigrant populations has begun in 2012. Primary Health Care received Department of Health NS Diversity Fund grant money and will be coordinating program and service delivery to off-reserve First Nations communities in 2011.		
Source: Primary Health Care	Frequency Tracked:	Last Updated: March 2012
Accountability: Barbara Hall		Next Update Expected: 2013

3.4.4 Patient Involvement in Patient Care Committees

Strategic Stream: Citizen Engagement and Accountability

Status: ☒ Did not meet the 2011/12 target	Trend: Not available at this time

Formula: Percent of patient care committees with at least one patient representative.

Description: Patient representation is required on Quality and Patient Safety Committees and accreditation teams. **Note:** Previous reports identified only the number of accreditation teams with patient representation. Quality and Patient Safety Committees are now responsible for accreditation; however, there are also accreditation teams in areas that have no Quality and Patient Safety Committee.

Our Promise: 2013 Milestones goals are to have 70% of patient care committees with patient representation by 2010/11, 90% by 2011/12, and 100% by 2012/13.

The Engagement Policy (CH-70-080) requires patient representation on patient care committees and accreditation teams.

Analysis and Progress: 55% of quality teams, councils, and committees in CDHA have patient or family representatives (41 of 75). This is short of the 2011/12 target of 90%.

The denominator (75) is comprised of:

- 65 quality teams or committees related to individual units/departments/services
- 10 councils or committees based on similar services or location
- Denominator will fluctuate as teams reorganize due to structural changes within the organization

Six introductory citizen engagement sessions to help teams constructively integrate patient and family representation are scheduled between June and September 2012 at various locations throughout the district. Follow-up sessions will be planned according to need.

Source: Performance Excellence	Frequency Tracked: Quarterly	Last Updated: May 2012
Accountability: Geoff Wilson		Next Update Expected: August 2012

3.4.5 Immunization Rate - Capital Health Flu Campaign

Strategic Stream: Citizen Engagement and Accountability

Status: ☒ Not meeting target

Trend: Improvement over the 2010/11 flu season

Formula: The number of Capital Health-paid workers receiving immunizations, divided by the total number of Capital Health-paid workers, multiplied by 100.

Description: The Department of Health made health care workers a key component of the annual influenza immunization program in the year 2000. Capital Health has been striving to increase the numbers of employees, volunteers, and students who are immunized each fall. Receiving the flu shot is important for all health care workers and caregivers who come in close contact with patients. It is a precaution taken to protect all patients, especially those who are over age 65 with weaker immune systems, and patients of any age with a chronic illness. The H1N1 Pandemic in the fall of 2009 resulted in an urgent need for those working in healthcare to be immunized.

Analysis and Progress: The following table shows a breakdown of the number of Capital Health workers who received flu vaccines in the 2009/10 to 2011/12 flu seasons. It should be noted the seasonal flu vaccine and the H1N1 flu vaccine were administered separately in 2009/10 and so are reported separately as two numbers. In 2010/11 and 2011/12, flu vaccines (including H1N1) were combined as a single administration, so only a single number is reported under the name, "seasonal flu vaccine."

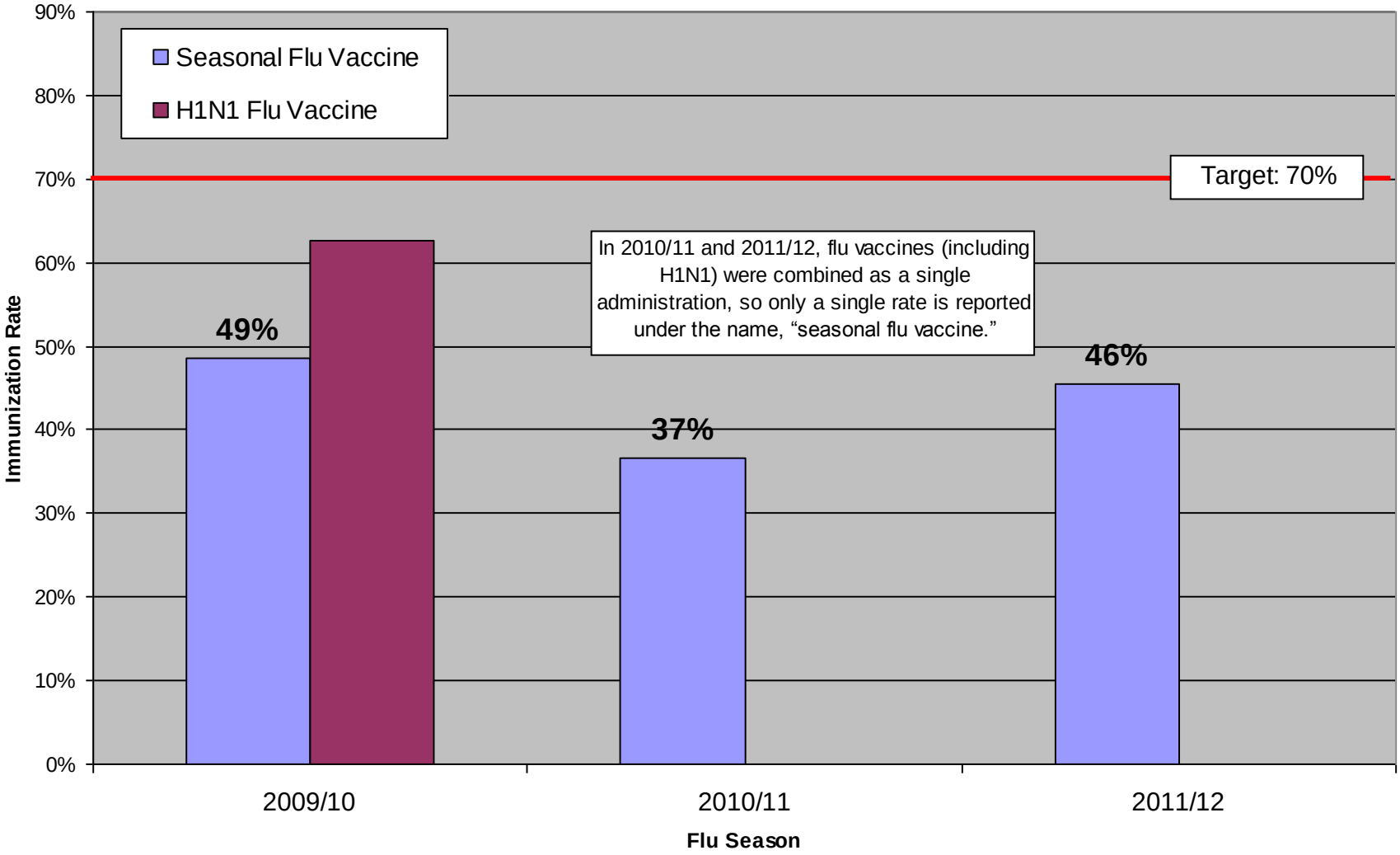
Group	2009/10	2010/11	2011/12
Capital Health-paid workers who received the *H1N1* flu vaccine	7,264	n/a	n/a
Capital Health-paid workers who received the *seasonal* flu vaccine	5,642	4,037	5,028
Total Capital Health-paid workers	11,610	11,051	11,042
Total non-Capital Health-paid workers (staff physicians, students, volunteers, contacted workers, etc.) who received the *H1N1* flu vaccine	2,257	n/a	n/a
Total non-Capital Health-paid workers (staff physicians, students, volunteers, contacted workers, etc.) who received the *seasonal* flu vaccine	1,557	965	1,017
Total Capital Health workers who received the *H1N1* flu vaccine	**9,521**	**n/a**	**n/a**
Total Capital Health workers who received the *seasonal* flu vaccine	**7,199**	**5,002**	**6,045**

The graph below shows the *percentage* of Capital Health-paid workers who were immunized in the 2009/10 to 2011/12 flu seasons. Non-Capital Health-paid workers are not shown on the graph because the denominator required for the calculation of percent (total non-Capital Health-paid workers) is difficult to determine. Efforts continue towards attaining and exceeding the national healthcare industry target of 70% immunization.

Source: Occupational Health	Frequency Tracked: Annually	Last Updated: March 2012
Accountability: Kathy MacNeil		Next Update Expected: March 2013

Percent of Capital Health-Paid Staff Immunized

2009/10 to 2011/12 Flu Seasons



3.5 Innovation and Learning

This section contains indicators related to grants and contracts, alternate revenue sources, technological innovation, business plan engagement, and multidisciplinary teams.

3.5.1 Models of Care Implementation in Patient Care Service Areas		
Strategic Stream: Innovation and Learning		
Status: ☑ Has met the 2011/12 target.	Trend: n/a	
Formula: Number of units that have implemented Model of Care divided by the total number of units, multiplied by 100.		
Description: Models of Care implementation is the differentiation of practice among nursing professionals. The Our Promise Milestones are to have MoC reviews completed in 38% of acute and sub-acute inpatient units by 2010/11, in 56% of units by 2011/12, and in 75% of units by 2012/13.		
Analysis and Progress: MoC implementation has been implemented in more than 75% of in-patient units, thus **this milestone has been achieved**. Furthermore, 5 (i.e., physiotherapy, occupational therapy, dietary, recreational therapy, and pharmacy) of 8 additional health care disciplines have completed work to differentiate practice within their disciplines. Analysis of in-patient units and MoC work has led to an innovative approach to more fully realize Our Promise of a People-Centred Haven of Health. Specifically, a cross-organizational team led by Professional Practice and consisting of employees representing acute, sub-acute, and critical care units, finance, performance excellence, transformation, learning and development, citizen engagement, and decision support, have designed processes to: (1) understand the needs of patients from the perspective of patients and families, (2) determine which of these patient needs should be addressed during an acute care in-patient stay, (3) identify the disciplines and optimal team mix required to meet these needs with special consideration of the role of patients and families, and (4) develop collaborative team processes needed to enact care teams. This work, the Collaborative Care Initiative (CCI), is currently underway. A recommendation for a new milestone relating to CCI is being developed.		
Source: Professional Practice	Frequency Tracked: Quarterly	Last Updated: June 2012
Accountability: Mary Ellen Gurnham		Next Update Expected: September 2012

3.5.2 Service Duplication & Fragmentation in Ambulatory Services		
Strategic Stream: Innovation and Learning		
Status: △ Caution – needs work to meet the 2011/12 target	Trend: n/a	
Formula: Under construction		
Description: Patients are not served well by fragmentation and duplication of fundamental services. Reduction will be in ambulatory clinics that treat similar/same patient populations with the similar/same desired outcomes. Every attempt will be made to develop care teams focused on one-stop service to patients with co-morbidities and eliminating non-value added processes. This Milestone is meant to apply to all Ambulatory Care areas. The Our Promise Milestones are to eliminate service duplication and fragmentation in ambulatory care services by 10% in 2010/11, by 40% in 2011/12, and by 100% in 2012/13.		
Analysis and Progress: This work is being overseen by the Ambulatory Redesign Task Force. The VPs of Person-Centred Health are poised to activate with their directors and managers, the actual plan to attain these targets. They will report progress through the Ambulatory Care Council. The patient registration kiosk project is an important part of this Milestone. Kiosk implementation work is complete for the HI site, with plans to consider implementation for OT/PT. Kiosk implementation is also complete for certain clinics at the VG site. The target has been met for this period and there is a trend of continued deployment where needed.		
Source: Raymond LeBlanc	Frequency Tracked: not certain	Last Updated: March 2012
Accountability: Paula Bond		Next Update Expected: not certain

3.5.3 *Ambulatory Care Visits*		
Strategic Stream: Innovation and Learning		
Status: ☒ Not meeting the 2011/12 target	Trend: n/a	
Formula: n/a		
Description: The Our Promise Milestones are to reduce ambulatory care visits by 10% in 2010/11, by 15% in 2011/12, and by 20% in 2012/13. This is to be done by increasing primary care capacity. Reduction in ambulatory clinics will be achieved by reviewing appropriateness of visits and targeting return visits. This will be achieved through better integration with the Primary Care services which to date has been a parallel process.		
Analysis and Progress: This work is being overseen by the Ambulatory Redesign Task Force. The VPs of Person-Centred Health are poised to activate with their directors and managers, the actual plan to attain these targets. They will report progress through the Ambulatory Care Council.		
Source:	Frequency Tracked: not certain	Last Updated: November 2010
Accountability: Paula Bond		Next Update Expected: not certain

3.5.4 *Capacity and Use of Web-Based Technologies*		
Strategic Stream: Innovation and Learning		
Status: ☑ Met the 2011/12 target	Trend: n/a	
Formula: Number of external web hits in the current time frame divided by the number of external web hits from the 2009/100 baseline.		
Description: Increased capacity and use of web based technology will enable integration of information and improved flow capacity. It will also enhance the patient experience by providing remote access to functions such as registration and scheduling. There will also be increased access to pertinent health information supporting patient self confidence and self management of health matters. The Our Promise Milestones are to increase use of web-based technologies by 10% in 2010/11, by 15% in 2011/12, and by 25% in 2012/13.		
Analysis and Progress: With 696,713 external web hits in Q4 of 2009/10 as a baseline, the number of hits increased by 14% in Q4 2010/11 to surpass the 10% target. In Q4 of 2001/12, the number of external web hits increased by 46% over the 2009/10 baseline, far surpassing the 15% target. There are continued enhancements to the CDHA website. Planned changes include: improved maps, new home page and enhanced use of media (photos and videos). In keeping with transparency, more content previously intended for the intranet is now available on our public site.		
Source: eHealth	Frequency Tracked: Quarterly	Last Updated: May 2012
Accountability: Amanda Whitewood		Next Update Expected: August 2012

3.5.5 Patient Registration in STAR		
Strategic Stream: Innovation and Learning		
Status: ☑ Met the 2011/12 target		Trend: improving
Formula: Number of service areas transitioned to STAR registration divided by the number of service areas identified as not compliant.		
Description: The Our Promise Milestone is to have 70% of Capital Health patient interactions registered in STAR by 2010/11, 85% by 2011/12, and 100% by 2012/13. This milestone will enable patient tracking and a complete patient record. eHealth knows of 25 service areas that are non-compliant, but are also looking to services to make the connection to become compliant.		
Analysis and Progress: Most patients arriving for clinics on the 4th floor at the HI are using the self-serve registration kiosks. Several services at the Dickson building are also using the kiosks in the lobby. Additional services continue to be added and Cobequid Centre will be addressed in fiscal 2012/13.		
Source: eHealth	Frequency Tracked: Quarterly	Last Updated: May 2012
Accountability: Amanda Whitewood		Next Update Expected: August 2012

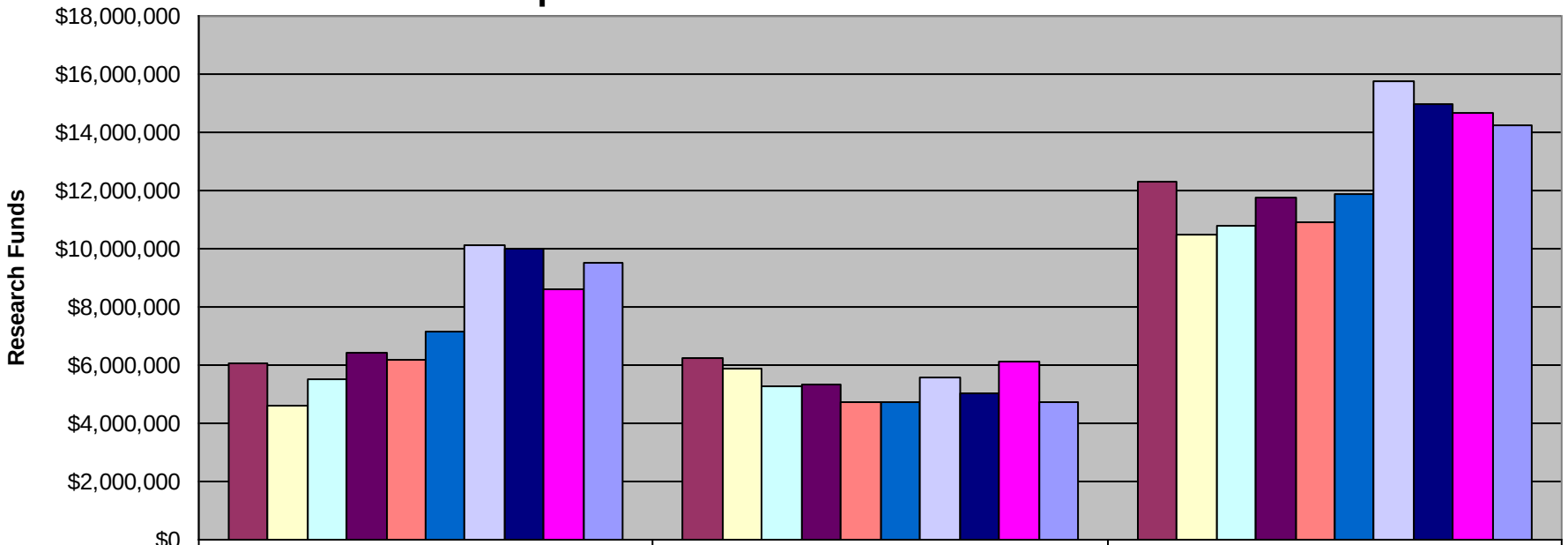
3.5.6 *Patient Appointments Self-Managed Through Technology*		
Strategic Stream: Innovation and Learning		
Status: ☑ Met the 2011/12 target		Trend: n/a
Formula: Number of current opportunities for self management divided by the number of previous opportunities for self management		
Description: Increased capacity and use of technology will enhance the patient experience by supporting functions such as automated appointment reminders and registration check-in. There will also be increased access to pertinent health information supporting patient self confidence and self management of health matters. The Our Promise Milestones are to increase opportunities for patients to self-manage appointments through the use of technologies by 0% in 2010/11, by 15% in 2011/12, and by 25% in 2012/13.		
Analysis and Progress: Currently, automated appointment reminders are in place for the Department of Medicine, the Provincial Breast Screening Program, Perinatal, Diabetic Management Clinic and Community Health Teams. Department of Surgery, Orthopedics, Vascular Lab and Urology are in the final stage of testing and are expected to go live in the next four to six weeks. The next area to be completed will be Preadmissions for the QEII. Note: Patient self registration will not be enabled through the PHS Browser Enabled Module (BEM). BEM will help family doctors book appointments for patients and we are targeting the first quarter of 2013 if resources are available to manage this process. Patient self registration would be a feature that might come with a provincial patient health record (such as RelayHealth). It would not be through PHS or CH STAR directly.		
Source: eHealth	Frequency Tracked: Quarterly	Last Updated: May 2012
Accountability: Amanda Whitewood		Next Update Expected: August 2012

3.5.7 *Resource the Information Management Strategic Plan*		
Strategic Stream: Innovation and Learning		
Status: ☑ Met the 2011/12 target	Trend: n/a	
Formula: n/a		
Description: Increased capacity and use of technology will improve service delivery, support evidence-based decision making and enhance the patient experience. The Our Promise Milestones are to resource the Capital Health Information Management Strategic Plan with $400,000 by 2010/11, $600,000 by 2011/12, and with $800,000 by 2012/13.		
Analysis and Progress: Tangible Capital Asset submission has been sent to the Department of Health and Wellness for computerized physician order entry (CPOE) funding. A proposal is in final stages for submission to Canada Health Infoway for Ambulatory Care electronic medical record (EMR). An RFP draft is ready to be shared with internal stakeholders to finalize needs so that it can be released to implement CPOE, electronic clinical documentation, and positive patient identification. The business planning process has secured just over 2.5 million to enable the beginning of the EMR work at Capital Health. While a bit behind schedule, it is very exciting to see this work start to come together.		
Source: eHealth	Frequency Tracked: Quarterly	Last Updated: May 2012
Accountability: Amanda Whitewood		Next Update Expected: August 2012

3.5.8 Research Funds from Grants & Contracts		
Strategic Stream: Innovation and Learning		
Status: No target	Trend: Decreasing grants, increasing contracts	
Formula: Total new dollars in grant and contract research received during the period		
Description: Research Services provides research infrastructure and administrative support to over 150 researchers including budget and contract negotiation for clinical trials, ethical review, and human resources administration as well as a comprehensive education and quality program. Research Services manages more than 1,380 active research projects which includes contract and grant funded research, and is responsible to ensure that all legal, financial, and ethical requirements and approvals for research at Capital Health are fulfilled. There are 260 research employees who are often integral members of the interdisciplinary healthcare teams providing quality patient-centered care at Capital Health.		
Analysis and Progress: Total research funds broken down into grants and contracts are shown in the graph below. More large granting opportunities are available as a national trend. Capital Health researchers have been the recipients of several of these large grants. Additional project management resources have been provided to ensure these projects are successful at every level.		
Source: Centre for Clinical Research	Frequency Tracked: Annually	Last Updated: May 2011
Accountability: Raymond LeBlanc, Lisa Underwood		Next Update Expected: July 2012

Total Research Funds from Grants and Contracts

Capital Health 2001/02 to 2010/11



	Grants	Contracts	Total
2001/02	$6,045,450	$6,268,024	$12,313,474
2002/03	$4,602,772	$5,853,207	$10,455,979
2003/04	$5,500,127	$5,299,324	$10,799,451
2004/05	$6,450,879	$5,308,993	$11,759,872
2005/06	$6,178,201	$4,723,990	$10,902,191
2006/07	$7,139,344	$4,756,286	$11,895,630
2007/08	$10,145,552	$5,586,147	$15,731,699
2008/09	$9,993,550	$5,004,082	$14,997,632
2009/10	$8,580,795	$6,095,198	$14,675,993
2010/11	$9,485,073	$4,739,574	$14,224,647

APPENDIX A: Summary of Milestone Progress with Respect to 2011/12 Targets

The following table is a Milestone-specific update to the end of the second year (2011/12) and this version was placed in this report for the May 2012 version.

LEGEND	Has Met Target	Trending Toward Target	Needs Work	Concern	Did Not Meet Target

	Milestone	VP Accountability	2011/12 Target	2011/12 Result	Last Status Update Received	Trend	Summary
Person-Centered Health Care	100% Elimination of shadow charts	Amanda Whitewood	50%		May 2012	Improving	Fell short of target for 2011/12, but there has been a notable change in the concern regarding the elimination of shadow charts over the last three years. Work continues with service areas.
	↓ Preventable surgical cancellations by 50%	Paula Bond	35%		May 2012	Surpassed Target	The target was surpassed for the last four months of 2011/12 with a trend of continued improvement.
	Wait time measures meet /exceed national standards	Paula Bond	50%		May 2012	Concern	Meeting Targets: hip fracture repair, hip replacement, cataract surgery, open heart surgery. Not Meeting Targets: CT, MRI, radiotherapy, knee replacement, ED waits.
	↓ no shows & cancellations by 50%	Paula Bond	35%		May 2012	Needs work	Surgery cancellations targets being met. Mental Health patient-related cancellations met target, but no shows did not. Dept. of Medicine cancellation rates are higher than 2009/10 baseline. No shows decreased by 10%.
	ALOS vs. ELOS met for all CMGs	Paula Bond	70%		May 2012	Will Not Meet Target	Will not meet target based on Apr. – Feb. 2012 results (only at 51%)
	↓ conservable days by 5% for typical cases (high control)	Paula Bond	4%		May 2012	On Target	If Apr.-Feb. 2012 trends continue, the 2011/12 target will be met.
	↓ occupancy rate to 90%	Paula Bond	91%		May 2012	Concern	QEII surgical as well as QEII & DGH ICUs met the 2011/12 target. All other areas failed to meet the target.
Sustainability	25% CH population have access to a primary health team	Barbara Hall	15%		Mar 2012	On Target	Target of 20% of family physicians (in full service practices) practicing within an interdisciplinary team. Target achieved as of March 2011.
	Increased investment in primary care & care of the elderly	Barbara Hall	+1% over 2010/11		Nov 2011	On Target	Targeted investment money in the amount of $690,000 has been authorized for the 2011/12 fiscal year, thus the 2011/12 target of a 1% increase

	Milestone	VP Accountability	2011/12 Target	2011/12 Result	Last Status Update Received	Trend	Summary
							over 2010/11 has been exceeded.
	75% of ALC beds vacated closed – resources reinvested	Barbara Hall	60%		Apr 2012	Needs Work	37% of ALC beds were closed at the end of 2011/12.
	Improved metabolic targets pre-diabetes & diabetes	Barbara Hall	30%		March 2012	Unknown	Expected to continue to improve over 2010/11. Awaiting more recent data.
	3% ↓ in hospital admissions for identified chronic diseases	Barbara Hall	2%		May 2012	Needs Work	For Apr.-Feb. 2012, the admission rates for chronic diseases, (diabetes, COPD, and heart failure/pulmonary edema) are all trending over target.
	10% ↓ readmit rates for cohorts with complex chronic disease	Barbara Hall	5%		Apr 2012	Needs Work	For April–February 2012, the readmission rate for diabetes is on track to meet the target for 2011/12, but the rates for COPD and heart failure/pulmonary edema are not.
	25% ↓ in volume of nursing home patients seen in the ED	Barbara Hall	15%		Mar 2012	Surpassed Target	The 2011/12 target of a 15% decrease from the baseline was surpassed with an actual decrease of 32%.
Transformational Leadership	10% improvement in absenteeism	Kathy MacNeil	7%		Apr 2012	Worsening	In 2011/12, average sick hours per employee per month were 3.0% *higher* than the baseline.—falling short of the target of a 7% *decrease* for 2011/12.
	10% improvement in overtime	Kathy MacNeil	7%		May 2012	On Target	In 2011/12 there was a 37% decrease from baseline. This surpasses the 2011/12 target.
	Improved overall recruitment rates	Kathy MacNeil	30%		May 2012	On Target	Recruitment has met the target by reducing the percentage of vacancies filled within 90 days. By implementing various initiatives and taking a proactive approach, the 2013 target is also expected to be met.
	Medical Department structures & operations aligned to achieve organizational goals	Ray LeBlanc	60%		May 2011	Unknown	Positive changes experienced. 2010/11 was a planning year for baseline targets.
	100% compliance with performance evaluation process	Kathy MacNeil	75%		April 2012	Improving	There are initiatives underway to address this milestone.
	90% of formal leaders consistently demonstrate transformational leadership competencies	Kathy MacNeil	75%		May 2012	Awaiting Measure-ment	2011 Employee Survey results show leader performance has risen on the dimensions of *Being* and *Doing*. Results on the Caring dimension fell slightly. New measures of this indicator are planned for Sept. 2012.

	Milestone	VP Accountability	2011/12 Target	2011/12 Result	Last Status Update Received	Trend	Summary
Citizen Engagement & Accountability	Receipt of health passport	Paula Bond	35%		Oct 2011	In Progress	Full organization launch for MyHeath Passport took place September / October 2011. The site has had 350+ hits since September. Measure under review.
	Influenced change in 3 major public health polices	Barbara Hall	+1 policy		May 2012	On Track	Public Health & Community Health focus. Target reached in 2011/12.
	25% ↑ access initiatives for underserved/ vulnerable groups	Barbara Hall	15%		March 2012	In Progress	Focused projects underway. Measurement of indicator is in development.
	100% patient involvement in patient care committees	Chris Power	90%		May 2012	Needs Work	55% of quality teams, councils, and committees in CDHA have patient or family representatives (41 of 75).
Innovation & Learning	Model of Care review complete in 75% of patient care services	Paula Bond	75%		May 2012	On Track	Has been implemented in 90% of in-patient units. As well, five of eight additional health care disciplines have completed work to differentiate practice within their disciplines.
	Eliminate service duplication & fragmentation in ambulatory services	Paula Bond	40%		Oct 2011	In Progress	Work underway with Ambulatory Care Group
	20% ↓ of ambulatory care RETURN visits	Paula Bond	15%		Sept 2011	Needs Work	Definition / Measure under review. Should pertain to RETURN visits only.
	25% ↑ in use of web-based technologies	Amanda Whitewood	15%		May 2012	On Target	In Q4 of 2001/12, the number of external web hits increased by 46% over the 2009/10 baseline, far surpassing the 15% target.
	100% patient interactions registered in STAR	Amanda Whitewood	85%		May 2012	On Track	Most 4th floor HI clinic patients are using the Kiosks and several Dickson building services are also using them. Additional services as well as Cobequid will be addressed in 2012/13.
	25% patient appointments self-managed through technology	Amanda Whitewood	15%		May 2012	In Progress	The use of automated call reminders has been increased in the EEG/EMG lab and the pulmonary function lab. Orthopedics and all surgery clinics at the HI site are in the process of moving forward with this initiative.
	Resourced the Information Management Strategic Plan	Amanda Whitewood	600k		May 2012	In Progress	The business planning process has secured 2.5 million+ to start work on an EMR. Proposals are underway to secure funding from other sources for additional projects.

APPENDIX B: Strategic Streams and Qmentum Quality Dimensions

This report has been organized around Capital Health's **Five Strategic Streams**:

1. **Person-Centered Health Care** – Person-centered health welcomes the patient as a full-fledged member of the health care team, respects their ownership and rights to their own health, and recognizes that a healthy person needs a healthy community. Capital health will care for the whole person before us with our hearts, as well as our hands and minds.

2. **Sustainability** - Capital Heath is transforming health care today because we want to be here for the people of our communities for a very long time. We are working to ensure our workforce will be sufficient to care for those we serve; buildings will be designed with the needs of patients citizens and the environment in mind; and all of this will happen on a budget that will not break the bank.

3. **Transformational Leadership** - Capital Heath invites every person to share their talents, act with passion and purpose, listen deeply, grow relationships, take risks and embrace tension to co-create a world-leading haven for people-centered health, healing and learning. We will focus on matching peoples' passion, talents and sense of purpose to the work rather than just focusing on the technical aspects of the job. We will create a culture and environment that fosters joy, pride, trust, and respect.

4. **Citizen Engagement & Accountability** - Capital Health is opening our doors, our minds, and our ears to connect with what communities really need. We are committed to a health system where each of us shares in the accountability for our individual health, the health of our health system and that of our community.

5. **Innovation & Learning** - Capital Health will contribute to a better tomorrow as lifelong learners, educators of the next generation, and researchers of new frontiers in health and healing. We will keep the spark of curiosity alive, and encourage it in everyone—whether they're at the bedside, in the boardroom, or in the lab. Constantly asking why will help us find a better way.

In addition, each indicator found within Capital Health's Strategic Indicators Report falls into one of the eight Qmentum quality dimensions outlined by Accreditation Canada (http://www.accreditation.ca/en/default.aspx). The quality dimensions are listed below.

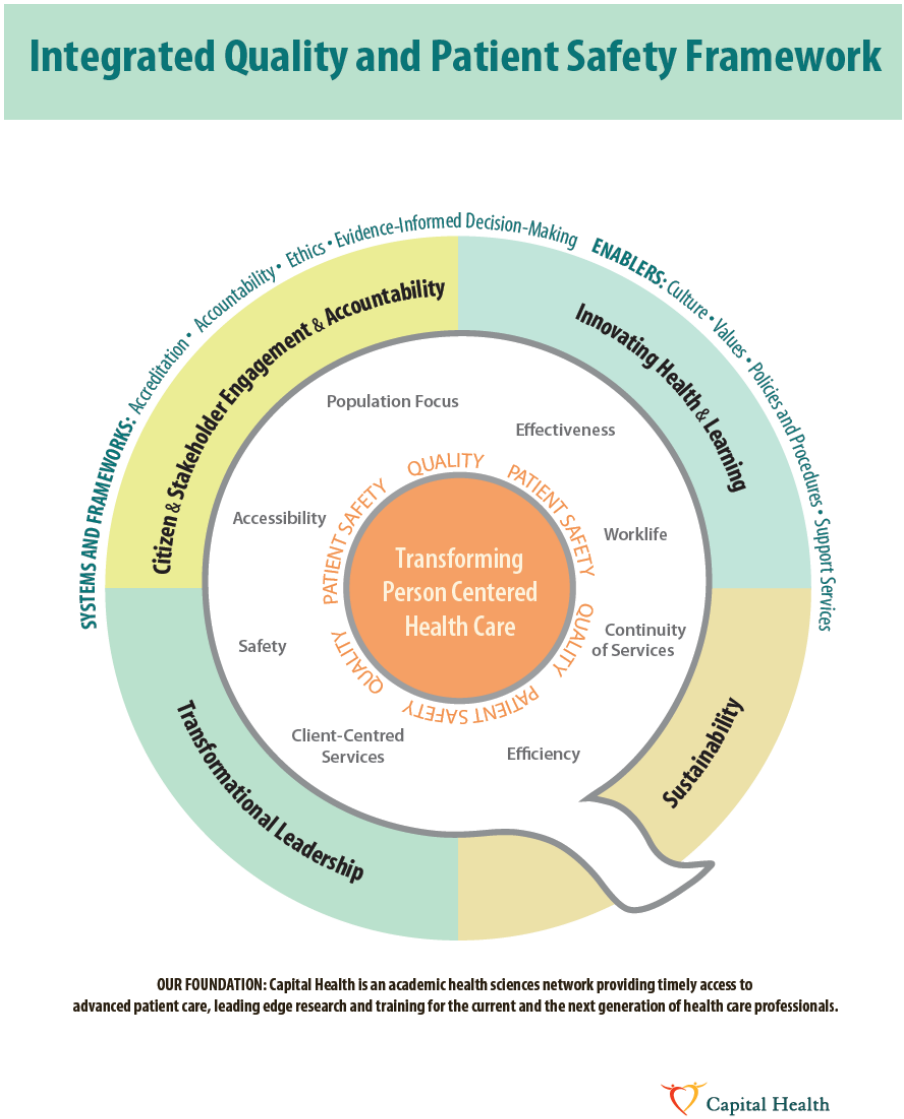
Qmentum Quality Dimensions:

- **Population Focus** - working with communities to anticipate and meet needs
- **Accessibility** - providing timely and equitable services
- **Safety** - keeping people safe
- **Worklife** - supporting wellness in the work environment
- **Client-centred services** – putting clients and families first
- **Continuity of Services** – experiencing coordinated and seamless services
- **Effectiveness** - doing the right thing to achieve the best possible results
- **Efficiency** - making the best use of resources

APPENDIX C: Quality and Patient Safety Framework

The Integrated Quality and Patient Safety Framework shown on the right outlines the quality and patient safety structure, functions, responsibilities and accountabilities at Capital Health. The framework is not a stand alone document – it is supported by Our Promise, Our Declaration of Health, the Patient Safety Plan, Our 2013 Milestones, our Strategic Indicators Reporting Framework, Capital Health Ethics Framework, Research Ethics Framework, and many other educational offerings and research opportunities. It provides information and guidance to the organization for selection and measurement of our achievements in service quality, care outcomes, and risk mitigation. It is not intended to be a detailed procedure for designing or implementing quality and patient safety initiatives. The framework is reviewed on a regular basis to ensure continued alignment with the vision mission and strategic direction of Capital Health.

This framework was developed in 2010 and first appeared in the October 2010 version of this report—replacing the Framework for Developing and Reporting of Operational Measures.



APPENDIX D: Contributors

Many people contributed to the preparation of this report. In particular:

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